Appointment

From: Christian, Megan [Christian.Megan@epa.gov]
Sent: 5/21/2020 2:57:25 PM
To: Leadership_Regional_Administrators [Leadership_Regional_Administrators@epa.gov]; Regional_Chiefs_of_Staff [Regional_Chiefs_of_Staff@epa.gov]; Wheeler, Kevin [Wheeler.Kevin@epa.gov]; Leadership_Assistant_Administrators [Leadership_Assistant_Administrators@epa.gov]; Cascio, Wayne [Cascio.Wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]; Mehaffey, Megan [Mehaffey.Megan@epa.gov]; Baynes, Jeremy [baynes.jeremy@epa.gov]; Bolen, Brittany [bolen.brittany@epa.gov]; Schiermeyer, Corry [schiermeyer.corry@epa.gov]; Leadership_Associate_Administrators [Leadership_Associate_Administrators@epa.gov]
CC: Robbins, Chris [Robbins.Chris@epa.gov]; Hackett, Jonathan [hackett.jonathan@epa.gov]; Tatum, Stephen [Tatum.Stephen@epa.gov]; Deziel, Dennis [Deziel.Dennis@epa.gov]; Lopez, Peter [lopez.peter@epa.gov]; Gulliford, Jim [gulliford.jim@epa.gov]; Munoz, Charles [munoz.charles@epa.gov]; Idsal, Anne [idsal.anne@epa.gov]; Busterud, John [Busterud.John@epa.gov]; Sethuraman, Jag [Sethuraman.Jag@epa.gov]; Sopkin, Gregory [sopkin.gregory@epa.gov]; Hage, Christopher [hage.christopher@epa.gov]; McQueen, Ken [McQueen.Ken@epa.gov]; Bloom, David [Bloom.David@epa.gov]; Thiede, Kurt [thiede.kurt@epa.gov]; Wright, Peter [wright.peter@epa.gov]; Leopold, Matt (OGC) [Leopold.Matt@epa.gov]; Ross, David P [ross.davidp@epa.gov]; Cherry, Katrina [Cherry.Katrina@epa.gov]; Garvey, Megan [garvey.megan@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]; Ashbee, Blake [ashbee.blake@epa.gov]; Hladick, Christopher [hladick.christopher@epa.gov]; Benevento, Douglas [benevento.douglas@epa.gov]; Dixon, Sean [dixon.sean@epa.gov]; Liebau, Joseph [Liebau.Joseph@epa.gov]; Dunlap, David [dunlap.david@epa.gov]; Rodan, Bruce [rodan.bruce@epa.gov]; Dunn, Alexandra [dunn.alexandra@epa.gov]

Subject: RA Call
Location: Microsoft Teams Meeting

Start: 5/22/2020 5:30:00 PM
End: 5/22/2020 6:30:00 PM
Show Time As: Tentative

Demonstration of ORD Modeling Tool of Gating Criteria

Note: Assistant Administrators and Associate Administrators are invited to attend.

Instructions to join:

1. Recommend joining the Teams meeting 5-10 minutes early to troubleshoot technological issues
2. Please disconnect from VPN/Pulse Secure, as the connecting interferes with the Microsoft Teams system
3. Please mute your computers and phones to prevent an echo.

Join Microsoft Teams Meeting

Ex. 6 Personal Privacy (PP) United States, Washington DC (Toll)

Conference ID: Ex. 6 Personal Privacy (PP)

Local numbers | Reset PIN | Learn more about Teams | Meeting options

---

Appointment

From: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]
Sent: 5/14/2020 2:50:56 PM
To: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]; Robbins, Chris [Robbins.Chris@epa.gov]; Dunlap, David [dunlap.david@epa.gov]; Cascio, Wayne [Cascio.Wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]; Baynes, Jeremy [baynes.jeremy@epa.gov]; Mehaffey, Megan [Mehaffey.Megan@epa.gov]

Subject: Gating Criteria
Location: Microsoft Teams Meeting

Start: 5/15/2020 1:00:00 PM
End: 5/15/2020 1:30:00 PM
Show Time As: Busy

Join Microsoft Teams Meeting

Ex. 6 Personal Privacy (PP) United States, Washington DC (Toll)

Conference ID: Ex. 6 Personal Privacy (PP)

Local numbers | Reset PIN | Learn more about Teams | Meeting options

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Appointment

From: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]
Sent: 5/20/2020 2:15:49 PM
To: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]; Leadership_Regional_Administrators [Leadership_Regional_Administrators@epa.gov]; Regional_Chiefs_of_Staff [Regional_Chiefs_of_Staff@epa.gov]; Leadership_Assistant_Administrators [Leadership_Assistant_Administrators@epa.gov]; Cascio, Wayne [cascio.wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]; Mehaffey, Megan [Mehaffey.Megan@epa.gov]; Baynes, Jeremy [baynes.jeremy@epa.gov]
CC: Robbins, Chris [Robbins.Chris@epa.gov]; Hackett, Jonathan [hackett.jonathan@epa.gov]; Tatum, Stephen [Tatum.Stephen@epa.gov]; Deziel, Dennis [Deziel.Dennis@epa.gov]; Lopez, Peter [lopez.peter@epa.gov]; Gulliford, Jim [gulliford.jim@epa.gov]; Munoz, Charles [munoz.charles@epa.gov]; Idsal, Anne [idsal.anne@epa.gov]; Busterud, John [Busterud.John@epa.gov]; Sethuraman, Jag [Sethuraman.Jag@epa.gov]; Sopkin, Gregory [sopkin.gregory@epa.gov]; Hage, Christopher [hage.christopher@epa.gov]; McQueen, Ken [McQueen.Ken@epa.gov]; Bloom, David [Bloom.David@epa.gov]; Thiede, Kurt [thiede.kurt@epa.gov]; Wright, Peter [wright.peter@epa.gov]; Leopold, Matt (OGC) [Leopold.Matt@epa.gov]

Subject: RA Call
Location: Microsoft Teams Meeting

Start: 5/22/2020 5:30:00 PM
End: 5/22/2020 6:30:00 PM
Show Time As: Busy

Demonstration of ORD Modeling Tool of Gating Criteria

Note: Assistant Administrators are invited to attend.

Join Microsoft Teams Meeting

Ex. 6 Personal Privacy (PP) United States, Washington DC (Toll)

Conference ID: Ex. 6 Personal Privacy (PP)

Local numbers | Reset PIN | Learn more about Teams | Meeting options

---

Appointment

From: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]
Sent: 5/14/2020 2:50:56 PM
To: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]; Robbins, Chris [Robbins.Chris@epa.gov]; Dunlap, David [dunlap.david@epa.gov]; Cascio, Wayne [Cascio.Wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]; Baynes, Jeremy [baynes.jeremy@epa.gov]; Mehaffey, Megan [Mehaffey.Megan@epa.gov]

Subject: Gating Criteria
Location: Microsoft Teams Meeting

Start: 5/15/2020 8:30:00 PM
End: 5/15/2020 9:00:00 PM
Show Time As: Busy

Join Microsoft Teams Meeting

Ex. 6 Personal Privacy (PP) United States, Washington DC (Toll)

Conference ID: Ex. 6 Personal Privacy (PP)

Local numbers | Reset PIN | Learn more about Teams | Meeting options

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Appointment

From: Benevento, Douglas [benevento.douglas@epa.gov]
Sent: 5/15/2020 7:23:36 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]

Subject: FW: Administrator Skype Briefing: ORD Modeling of Gating Criteria
Location: Skype Meeting (link in body of email)

Start: 5/15/2020 8:00:00 PM
End: 5/15/2020 9:00:00 PM
Show Time As: Tentative

-----Original Appointment-----
From: Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>
Sent: Friday, May 15, 2020 3:17 PM
To: Orme-Zavaleta, Jennifer; Cascio, Wayne; Benevento, Douglas; Dunlap, David; Molina, Michael; Gunasekara, Mandy; Vizian, Donna; Adm15Wheeler.Calendar; Baxter, Lisa; Baynes, Jeremy; Mehaffey, Megan
Cc: Christian, Megan; Scott, Corey; Hyman, Alana; Eng, Connie
Subject: Administrator Skype Briefing: ORD Modeling of Gating Criteria
When: Friday, May 15, 2020 4:00 PM-5:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Skype Meeting (link in body of email)

Join Skype Meeting

Trouble Joining? Try Skype Web App

Join by phone

Toll number: Ex. 6 Personal Privacy (PP) (Dial-in Number) English (United States)

Find a local number

Conference ID: Ex. 6 Personal Privacy (PP)

Forgot your dial-in PIN? | Help

Appointment

From: Gentry, Nathan [Gentry.Nathan@epa.gov]
Sent: 5/14/2020 2:50:54 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Robbins, Chris [Robbins.Chris@epa.gov]; Dunlap, David [dunlap.david@epa.gov]; Cascio, Wayne [Cascio.Wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]; Baynes, Jeremy [baynes.jeremy@epa.gov]; Mehaffey, Megan [Mehaffey.Megan@epa.gov]

Subject: Gating Criteria
Location: Microsoft Teams Meeting

Start: 5/15/2020 8:30:00 PM
End: 5/15/2020 9:00:00 PM
Show Time As: Tentative

Join Microsoft Teams Meeting

Ex. 6 Personal Privacy (PP) United States, Washington DC (Toll)

Conference ID: Ex. 6 Personal Privacy (PP)

Local numbers | Reset PIN | Learn more about Teams | Meeting options

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Appointment

From: Shaw, Betsy [Shaw.Betsy@epa.gov]
Sent: 5/12/2020 4:50:55 PM
To: Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]
CC: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]

Subject: OAR Town Hall

Start: 5/13/2020 6:00:00 PM
End: 5/13/2020 7:00:00 PM
Show Time As: Tentative

Lynnann and Jennifer, (and Donna if you're able to join us after all – I think I saw that you accepted the scheduling invitation),

I gave you the wrong call in number for tomorrow's OAR Town Hall from 2 – 3 p.m. You will want to dial in to the Leader line, which is Ex. 6 Personal Privacy (PP); conference id: Ex. 6 Personal Privacy (PP) Below is the agenda as it stands now. Holler you have any questions.

Thanks in advance for making the time to join us!

Betsy

OAR Town Hall Agenda

2:00 p.m.	Welcome and Opening Remarks - Anne Idsal
2:10 p.m.	Message from the Administrator - Andrew Wheeler
2:20 p.m.	Reopening Guidelines and various updates – Lynnann Hitchens, OMS
2:30 p.m.	Disinfecting Public Spaces – Jennifer Orme Zavaleta, ORD
2:40 p.m.	Q & A
3:00 p.m.	Adjourn

Appointment

From: Christian, Megan [Christian.Megan@epa.gov]
Sent: 5/20/2020 2:15:48 PM
To: Leadership_Regional_Administrators [Leadership_Regional_Administrators@epa.gov]; Regional_Chiefs_of_Staff [Regional_Chiefs_of_Staff@epa.gov]; Leadership_Assistant_Administrators [Leadership_Assistant_Administrators@epa.gov]; Cascio, Wayne [Cascio.Wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]; Mehaffey, Megan [Mehaffey.Megan@epa.gov]; Baynes, Jeremy [baynes.jeremy@epa.gov]
CC: Robbins, Chris [Robbins.Chris@epa.gov]

Subject: RA Call
Location: Microsoft Teams Meeting

Start: 5/22/2020 5:30:00 PM
End: 5/22/2020 6:30:00 PM
Show Time As: Tentative

Demonstration of ORD Modeling Tool of Gating Criteria

Note: Assistant Administrators are invited to attend.

Join Microsoft Teams Meeting

Ex. 6 Personal Privacy (PP) United States, Washington DC (Toll)

Conference ID: Ex. 6 Personal Privacy (PP)

Local numbers | Reset PIN | Learn more about Teams | Meeting options

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Message

From: Vizian.Donna@epa.gov [Vizian.Donna@epa.gov]
Sent: 5/19/2020 8:27:16 PM
To: Wells, Krysti [Wells.Krysti@epa.gov]
CC: Kamen, Mara [kamen.mara@epa.gov]; Hitchens, Lynnann [hitchens.lynnann@epa.gov]; Hart, Debbi [Hart.Debbi@epa.gov]; Hunt, Loretta [Hunt.Loretta@epa.gov]; Patterson, Nicole [Patterson.Nicole@epa.gov]
Subject: Re: two things for reopening

Thanks. Disappointing. I think by Thursday we will have something you can talk through...or Nicole can.

On May 19, 2020, at 2:22 PM, Wells, Krysti <Wells.Krysti@epa.gov> wrote:

Hey Folks –

Sorry for the delay in responding regarding the OPM meeting.

Ex. 5 Deliberative Process (DP)

Krysti Wells
Phone: (202) 564-6295

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Tuesday, May 19, 2020 10:54 AM
To: Kamen, Mara <kamen.mara@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Cc: Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Wells, Krysti <Wells.Krysti@epa.gov>
Subject: RE: two things for reopening

Thanks

How did the meeting with Tim Curry go yesterday? Doug tentatively said we can talk them through the guidance.

From: Kamen, Mara <kamen.mara@epa.gov>
Sent: Tuesday, May 19, 2020 10:33 AM
To: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>
Cc: Hart, Debbi <Hart.Debbi@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Wells, Krysti <Wells.Krysti@epa.gov>
Subject: two things for reopening

Just an FYI, there are two other HR pieces to consider as EPA returns to the workplace:

Ex. 5 Deliberative Process (DP)

OHR is working these issues. I just wanted to make sure you were aware.

If you have questions or need further information, please feel free to contact me.

Mara
Mara J. Kamen
Director, Office of Human Resources
Office of Mission Support
US Environmental Protection Agency
1200 Pennsylvania Ave. NW
Washington DC 20460
202.564.4606
kamen.mara@epa.gov

<image001.gif>

Appointment

From: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]
Sent: 5/20/2020 2:15:49 PM
To: Orme-Zavaleta, Jennifer [Orme-Zavaleta.Jennifer@epa.gov]; Leadership_Regional_Administrators [Leadership_Regional_Administrators@epa.gov]; Regional_Chiefs_of_Staff [Regional_Chiefs_of_Staff@epa.gov]; Wheeler, Kevin [Wheeler.Kevin@epa.gov]; Leadership_Assistant_Administrators [Leadership_Assistant_Administrators@epa.gov]; Cascio, Wayne [Cascio.Wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]; Mehaffey, Megan [Mehaffey.Megan@epa.gov]; Baynes, Jeremy [baynes.jeremy@epa.gov]; Bolen, Brittany [bolen.brittany@epa.gov]; Schiermeyer, Corry [schiermeyer.corry@epa.gov]; Leadership_Associate_Administrators [Leadership_Associate_Administrators@epa.gov]
CC: Robbins, Chris [Robbins.Chris@epa.gov]; Hackett, Jonathan [hackett.jonathan@epa.gov]; Tatum, Stephen [Tatum.Stephen@epa.gov]; Deziel, Dennis [Deziel.Dennis@epa.gov]; Lopez, Peter [lopez.peter@epa.gov]; Gulliford, Jim [gulliford.jim@epa.gov]; Munoz, Charles [munoz.charles@epa.gov]; Idsal, Anne [idsal.anne@epa.gov]; Busterud, John [Busterud.John@epa.gov]; Sethuraman, Jag [Sethuraman.Jag@epa.gov]; Sopkin, Gregory [sopkin.gregory@epa.gov]; Hage, Christopher [hage.christopher@epa.gov]; McQueen, Ken [McQueen.Ken@epa.gov]; Bloom, David [Bloom.David@epa.gov]; Thiede, Kurt [thiede.kurt@epa.gov]; Wright, Peter [wright.peter@epa.gov]; Leopold, Matt (OGC) [Leopold.Matt@epa.gov]; Ross, David P [ross.davidp@epa.gov]; Cherry, Katrina [Cherry.Katrina@epa.gov]; Garvey, Megan [garvey.megan@epa.gov]; Vizian, Donna [Vizian.Donna@epa.gov]; Ashbee, Blake [ashbee.blake@epa.gov]; Hladick, Christopher [hladick.christopher@epa.gov]; Benevento, Douglas [benevento.douglas@epa.gov]; Dixon, Sean [dixon.sean@epa.gov]; Liebau, Joseph [Liebau.Joseph@epa.gov]; Dunlap, David [dunlap.david@epa.gov]; Rodan, Bruce [rodan.bruce@epa.gov]; Dunn, Alexandra [dunn.alexandra@epa.gov]

Subject: RA Call
Location: Microsoft Teams Meeting

Start: 5/22/2020 5:30:00 PM
End: 5/22/2020 6:30:00 PM
Show Time As: Busy

Demonstration of ORD Modeling Tool of Gating Criteria

Note: Assistant Administrators and Associate Administrators are invited to attend.

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3. Please mute your computers and phones to prevent an echo.

Join Microsoft Teams Meeting

Ex. 6 Personal Privacy (PP) United States, Washington DC (Toll)

Conference ID: Ex. 6 Personal Privacy (PP)

Local numbers | Reset PIN | Learn more about Teams | Meeting options

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Appointment

From: Gentry, Nathan [Gentry.Nathan@epa.gov]
Sent: 5/14/2020 3:05:03 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Robbins, Chris [Robbins.Chris@epa.gov]; Dunlap, David [dunlap.david@epa.gov]; Cascio, Wayne [Cascio.Wayne@epa.gov]; Baxter, Lisa [Baxter.Lisa@epa.gov]; Baynes, Jeremy [baynes.jeremy@epa.gov]; Mehaffey, Megan [Mehaffey.Megan@epa.gov]

Subject: Gating Criteria
Location: Microsoft Teams Meeting

Start: 5/15/2020 1:00:00 PM
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Join Microsoft Teams Meeting

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Conference ID: Ex. 6 Personal Privacy (PP)

Local numbers | Reset PIN | Learn more about Teams | Meeting options

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Message

From: Braxton, Marilyn [Braxton.Marilyn@epa.gov]
Sent: 7/9/2020 7:36:53 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]
Subject: FW: HQ Phase 1 Status Update

Regards!
Marilyn A. Braxton, OMS Chief of Staff
202-564-8192
Ex. 6 Personal Privacy (PP) (mobile)

From: HQ_Facilities_Updates <HQ_Facilities_Updates@epa.gov>
Sent: Thursday, July 2, 2020 8:22 PM
To: All HQ Feds-nonFeds <All_HQ_Feds-nonFeds@epa.gov>
Subject: HQ Phase 1 Status Update

Status Update:

Agency experts continue to assess the National Capital Region's gating criteria and actions by state and local governments since the start of our entrance into Phase 1 on Tuesday, June 23rd. Consistent with the language in the Opening Up America Again Guidance, the 14-day trend data (June 23 to July 6) will be reviewed next Thursday in order to determine if the WJ Clinton Buildings (North, South, East and West) and our offices in the Ronald Regan Building and Potomac Yard Building should proceed to Phase 2 or stay in Phase 1.

As a reminder, employees are encouraged to continue teleworking in Phases 1 and 2. Please see the mass mailer issued on June 18, 2020 for more information.

The Agency continues to monitor the situation closely and adapt policies and procedures in accordance with CDC recommendations and local guidance. You can review the most recent data and trends on the Agency dashboard for additional information. (To access the dashboard, select "Enterprise login" and enter "EPA" in the box for "Your ArcGIS organization's URL," click continue, select EPA Enterprise and login with your EPA credentials.)

A mass mailer notification will be sent prior to moving into Phase 2 of the workplace return plan. More information will be provided as it becomes available.

Please review the following resources and helpful tips for employees:

EPA HQ Return to the Workplace Plan
EPA Self-Assessment Questionnaire
CDC How to Protect Yourself & Others

EPA COVID-19 intranet site
EPA Travel Guidelines During the Phased Return to Workplaces

Message

From: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Sent: 7/20/2020 4:09:06 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]
Subject: MM: EPA Phase 3 Guidance COVID-19 Update

Hi Donna, see below mm from Doug.

Shakeba Carter-Jenkins
Communications Director &
Senior Special Assistant
Office of Mission Support, U.S. Environmental Protection Agency
carter-jenkins.shakeba@epa.gov | 202-564-6385 | Ex. 6 Personal Privacy (PP) *(mobile) | WJC North 3330*
Mailing Address: 1200 Pennsylvania Avenue, NW, Washington, DC 20460

"I've learned you can tell a lot about a person by the way (s)he handles these three things: a rainy day, lost luggage, and tangled Christmas tree lights." Maya Angelou

From: MassMailer <massmailer@epa.gov>
Sent: Thursday, July 16, 2020 7:05 PM
To: MassMailer <massmailer@epa.gov>
Subject: EPA Phase 3 Guidance COVID-19 Update

Dear Colleagues,

We committed early on during the pandemic to put together plans for our eventual return to the office that protected e upon data and guidance from public health professionals. Along with placing a premium on employee safety these pla would be supplemented to consider feedback from the regions and national program managers. We want to provide a the Workplace Plan, specifically our supplemental agency guidance for Phase 3.

As the Administrator stated in his May 21st message, we are implementing a rolling reopening and moving through th collected on the EPA dashboard and considering what state and local governments are doing. Following these criteria and move through the phasing process considering conditions unique to the 125 EPA facilities across the country.

As the nation opens more businesses and resumes public activities, we've developed additional specific EPA Phase 3 guidance already in place. Consistent with the Administrator's June 11 Mass Mailer additional telework is available for

1. Are in a CDC at-risk category for COVID-19 or;
2. Live with someone in that at-risk category or;
3. Have dependent care responsibilities that are unresolved.

Additionally, employees with dependent care responsibilities may continue to work expanded hours and days. These f up to two months after entering Phase 3 and can be extended as appropriate. As discussed previously if mass transit that would also be a basis to grant additional telework.

Further, the Administrator has instructed the regions and NPMs that the first two weeks of Phase 3 are transitional. Ma employees on a rolling return during those first two weeks as part of the transition back into the workplace. Employees office and teleworking during this time. Also, managers are authorized during the first two months of Phase 3 to grant pay period if necessary, for appropriate social distancing.

We believe these additions to the Phase 3 plan will help provide for a safe return to the workplace for our employees. information provides reason for more updates, we will act.

Thank you for your work for the Agency.

Doug Benevento
Associate Deputy Administrator

Message

From: Bell, Matthew [Bell.Matthew@epa.gov]
Sent: 7/2/2020 3:55:01 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]
Subject: RE: VERSION 2 Spreadsheet Summary
Attachments: RE: one more ask

We had 125 locations last week. See email

Matthew Bell
Senior Advisor|Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, July 02, 2020 11:12 AM
To: Bell, Matthew <Bell.Matthew@epa.gov>
Cc: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Richardson, RobinH <Richardson.RobinH@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>; Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Alvarado, David <alvarado.david@epa.gov>; Baxter, Lisa <Baxter.Lisa@epa.gov>; Baynes, Jeremy <baynes.jeremy@epa.gov>; Robbins, Chris <Robbins.Chris@epa.gov>
Subject: Re: VERSION 2 Spreadsheet Summary

Matt what was the 1 facility we deleted?

> On Jul 2, 2020, at 8:07 AM, Bell, Matthew <Bell.Matthew@epa.gov> wrote:
>
> Lynnann,
>
> Below are some stats in case they are helpful for the paper.
>
> 125 locations listed
> - 78 in a Phase
> - 4 in Phase 2
> - 56 in Phase 1
> - 4 are co-located and could not be closed for Phase 0.
> - 18 in Phase 0
> - 47 not in a phase
> - 1 location listed as co-located, which means it cannot be closed for Phase 0 and is following other entity's plan
> - Note: CID locations cannot remain closed in Phase 0. As such, the maximum closure timeline for these locations is 7 days.

Matthew Bell
Senior Advisor|Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

From: Hitchens, Lynnann <hitchens.lynnann@epa.gov>
Sent: Thursday, July 02, 2020 10:15 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Richardson, RobinH <Richardson.RobinH@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>; Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>; Alvarado, David <alvarado.david@epa.gov>; Baxter, Lisa <Baxter.Lisa@epa.gov>; Baynes, Jeremy <baynes.jeremy@epa.gov>; Robbins, Chris <Robbins.Chris@epa.gov>
Subject: VERSION 2 Spreadsheet Summary

Please refer to this version for the meeting with Doug.

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management
Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

From: Hitchens, Lynnann
Sent: Thursday, July 2, 2020 10:01 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Orme-Zavaleta, Jennifer <Orme-Zavaleta.Jennifer@epa.gov>; Richardson, RobinH <Richardson.RobinH@epa.gov>; Cascio, Wayne <Cascio.Wayne@epa.gov>; Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>; Alvarado, David <alvarado.david@epa.gov>; Baxter, Lisa <Baxter.Lisa@epa.gov>; Baynes, Jeremy <baynes.jeremy@epa.gov>; Robbins, Chris <Robbins.Chris@epa.gov>
Subject: Spreadsheet Summary

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management
Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

-----Original Appointment-----
From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Friday, June 19, 2020 8:23 AM
To: Vizian, Donna; Hitchens, Lynnann; Orme-Zavaleta, Jennifer; Richardson, RobinH; Cascio, Wayne; Braxton, Marilyn; Bell, Matthew; Alvarado, David; Baxter, Lisa; Baynes, Jeremy; Robbins, Chris
Subject: General Discussion
When: Thursday, July 2, 2020 8:30 AM-11:00 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Microsoft Teams Meeting

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Ex. 6 Personal Privacy (PP) United States, Washington DC (Toll)

Conference ID: Ex. 6 Personal Privacy (PP)

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Message

From: Bell, Matthew [Bell.Matthew@epa.gov]
Sent: 6/25/2020 7:53:34 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]
Subject: RE: one more ask

76 in a Phase
49 not in a Phase
======
125 Total

Of those in a phase:
Phase 0 - 38
Phase 1 - 37
Phase 2 – 1

Note: 3 are listed as co-located but currently shown in Phase 0 (by default).

Sincerely,

Matthew Bell
Senior Advisor
Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 25, 2020 3:22 PM
To: Bell, Matthew <Bell.Matthew@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>
Subject: one more ask

Can you send me the number that are in each phase based on last weeks decisions

Message

From: Hitchens, Lynnann [hitchens.lynnann@epa.gov]
Sent: 6/26/2020 9:30:25 PM
To: Braxton, Marilyn [Braxton.Marilyn@epa.gov]; Bell, Matthew [Bell.Matthew@epa.gov]; Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
CC: Vizian, Donna [Vizian.Donna@epa.gov]
Subject: FW: Office Operations Update
Attachments: Cincinnati 6 26.PNG; Gating Criteria 6-26.PNG

FYI – Cincinnati notice.

Lynnann Hitchens
Acting Deputy Assistant Administrator for
Administration and Resources Management
Office of Mission Support
US EPA
P: 202-564-3184
M: Ex. 6 Personal Privacy (PP)

From: Caro, Vique <Caro.Vique@epa.gov>
Sent: Friday, June 26, 2020 12:05 PM
To: CI-ALL <CI-ALL@EPA.GOV>
Subject: Office Operations Update

Colleagues,

As stated last week, Administrator Wheeler has emphasized that our plan for a phased return to our offices is both measured and deliberate to minimize risk to your health. Our plan provides for a "rolling reopening," so each facility will proceed through the phases after a thorough review of health information that comprises the gating criteria outlined in the Opening Up America Again Guidance, while keeping in mind any city, state, or county requirements as well.

During the review of trend data this week for the Cincinnati locations, our Agency experts determined that the gating criteria to enter Phase I were not met and are in fact now trending upwards. Please see the attached charts demonstrating this trend upward. Because of this, it has been decided that we should extend our closure period until next week when we will decide if we should move into Phase 1. While we are considering other data and the posture of state and local governments when making phasing decisions, in this case we believed it was warranted to delay moving to Phase 1.

EPA space remains closed to ensure that any possible virus in those facilities is rendered inactive prior to employees' return. I understand that as the prolonged closure goes on there may need to be adjustments made to the facility access list. Any spaces that need to be accessed during the extended closure will be cleaned and disinfected before entering Phase 1. We will be following our own guidance on cleaning and disinfecting, which we developed with the Centers for Disease Control and Prevention (CDC), throughout this process. Please contact your supervisor should access to a facility during the extended closure needs to be requested. Access must be approved in advance.

Your health and safety are our top priority, and we will continue to keep you updated on the status of our locations.

Thank you.

Vique Caro

Office Director
Office of Administration and Resources Management Cincinnati
US Environmental Protection Agency

EPA Facility Status Dashboard - Draft version for Weekly Management Review

About | Home | Criteria I | Criteria II | Criteria III

Last updated: 06/24/2020

EPA Facilities

COVID-19 cases are not trending down

COVID-19 cases are trending down over the previous 7 days

COVID-19 cases are trending up over the previous 7 days

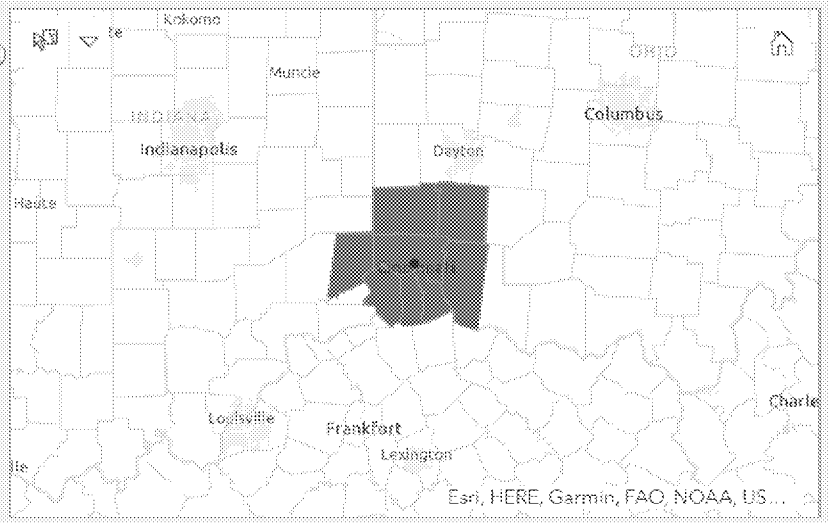
Region 10 Headquarters
1200 Sixth Avenue
Seattle, WA 98101-3188

RTP Main Campus
109 TW Alexander Drive
Durham, NC 27711-0000

Cincinnati Main Campus
26 Martin Luther King Drive West
Cincinnati, OH 45268-0000

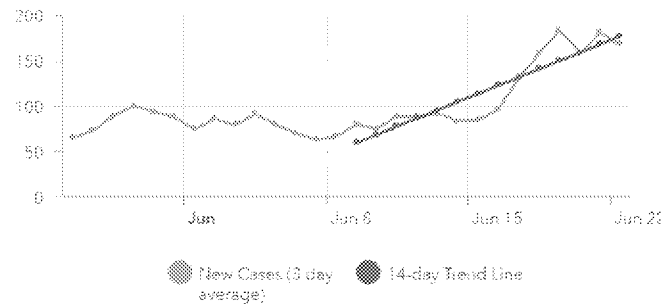
OAR - Lab - Ann Arbor MI
2565 Plymouth Road
Ann Arbor, MI 48105-0000

Region 2 - Lab - Edison NJ
2890 Woodbridge Avenue



Criteria II

Daily New Covid-19 Cases (previous 28 days)



See About Tab for how trend was determined

Population	Confirmed COVID-19	COVID-19 Incidence Rate
2,087,258	7,982	85.0 cases per 100,000 people

14 Day Trend

New COVID-19 cases are trending up over the previous 14 days

Goal: Downward trend for 14

14 Day Trend

This trend is statistically significant

p-value = 0.0001

Office

Lynnann, Updated

Colleagues

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Thank you

Vique Carc

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Office of

US Enviro

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EPA Facility Status Dashboard

About | Home | Criteria I | Criteria II | Criteria III

Last updated: 06/24/2020

For questions about this dashboard, https://intranet.epa.gov/about-ord/facility-reopening-dashboard-questions

EPA Facilities

- Facility is not meeting all criteria
- Facility is meeting all criteria over the previous 7 days
- Facility is meeting all criteria over the previous 14 days

Region 9 Headquarters
75 Hawthorne Street
San Francisco, CA 94105-3920

Region 10 Headquarters
1200 Sixth Avenue
Seattle, WA 98101-2152

RTP Main Campus
109 TW Alexander Drive
Durham, NC 27711-0000

Cincinnati Main Campus
26 Martin Luther King Drive West
Cincinnati, OH 45268-0000

OAR - Lab - Ann Arbor MI
2565 Plymouth Road
Ann Arbor, MI 48105-0000

Region 2 - Lab - Edison NJ
2890 Woodbridge Avenue
Edison, NJ 8837

AK
Region 10 - Field Office - Anchorage AK
222 West 7th Avenue
Anchorage, AK 99513-7583

AK

Criteria I

Downward trajectory of influenza and COVID-like illness (ILI / CLI) symptoms within 14-day period

Goal I-a: Number of reported weekly new ILI symptoms averaged over the states that intersect the commuting area trends down over a 4-week period

AND

Goal I-b: Number of reported weekly new CLI symptoms

Goal I-a

Statewide ILI Symptoms are trending down or there is minimal ILI activity

Goal I-b

tbd

Criteria II

Documented COVID-19 cases and prevalence of positive tests must trend downward for 14 days (while not decreasing the overall number of tests

Goal II-a: Number of reported daily new cases in the commuting area trends down over a 14-day period

OR

Goal II-b: Number of reported positive tests in the commuting area trends down over a 14-day period

OR

Goal II-c: Incidence over the previous 14 days is less than 10

Goal II-a

New COVID-19 cases are not trending down over the previous 14 days

Goal II-b

tbd

Goal II-c

Incidence over last 14 days

85.0

cases per 100,000 people

Criteria III

Local hospitals must have the capacity to treat all patients without crisis care and jurisdictions must have a robust healthcare worker testing program and plan in place

Goal III-a: ICU bed capacity for all hospitals in the commuting area is greater than 20%

AND

Goal III-b: Percent of positive tests averaged over the states that intersect the commuting area is below 20%

Goal III-a

ICU Capacity Remaining

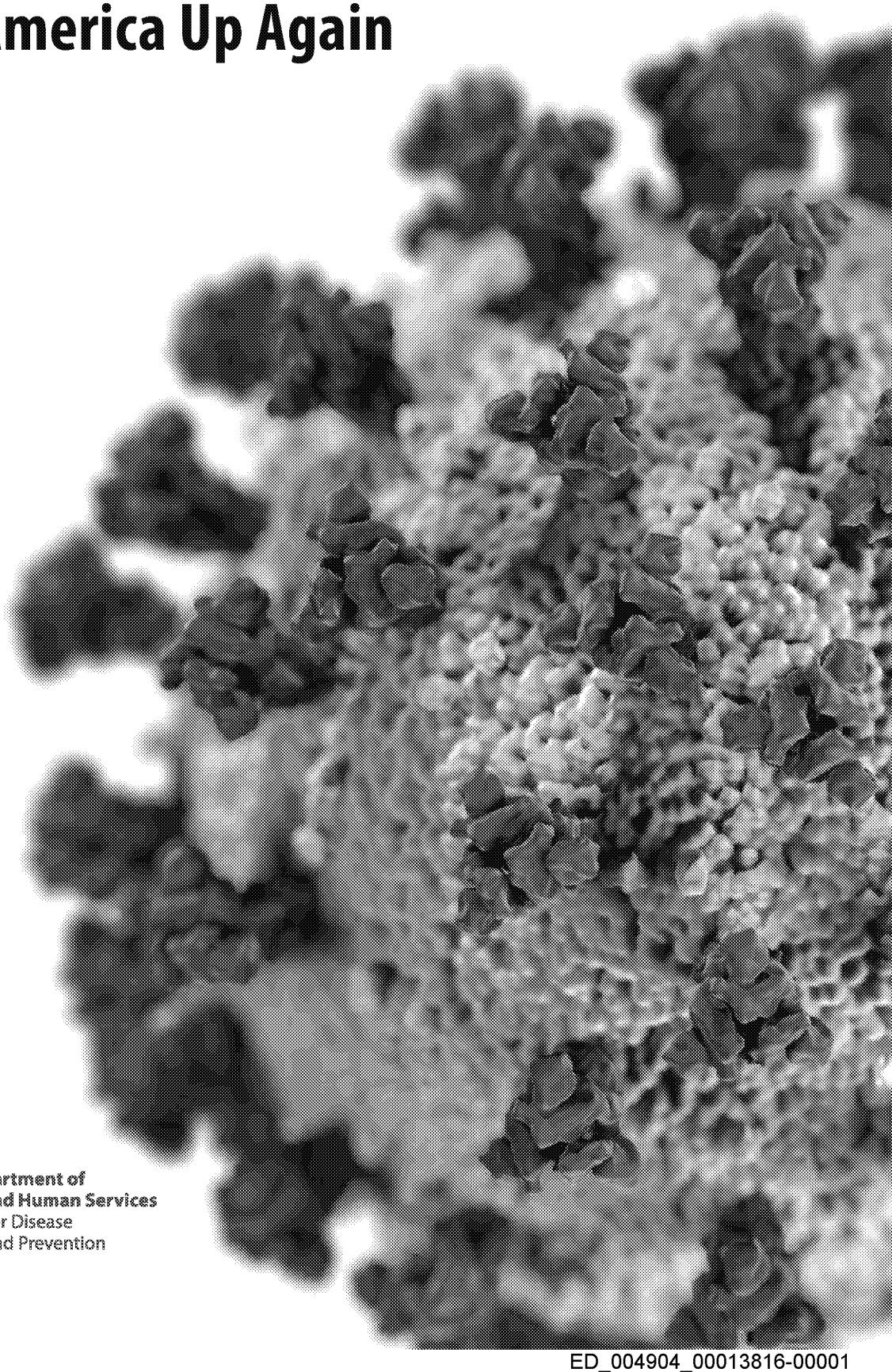
22.7%

Goal III-b

Percent of COVID-19 tests that are positive

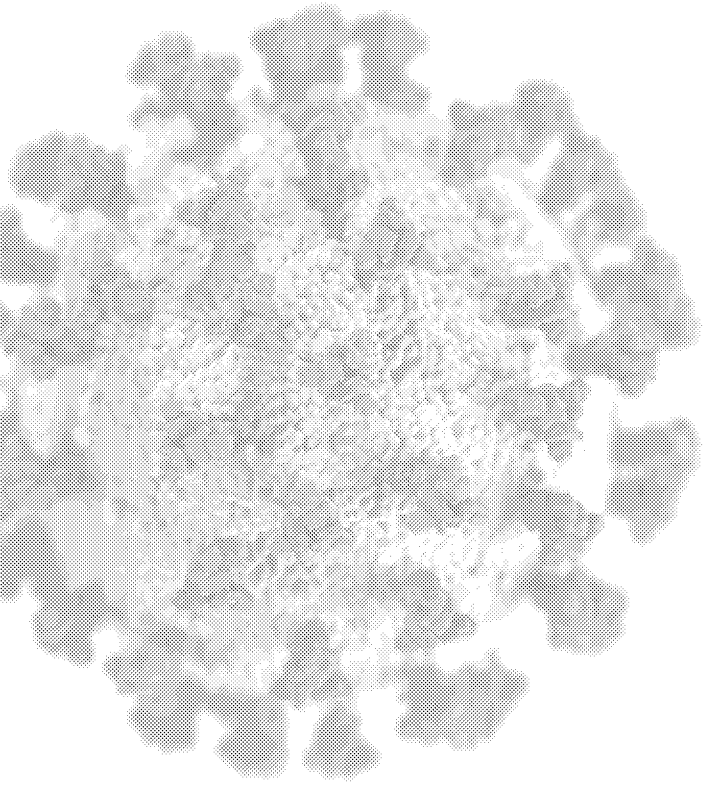
7.5%

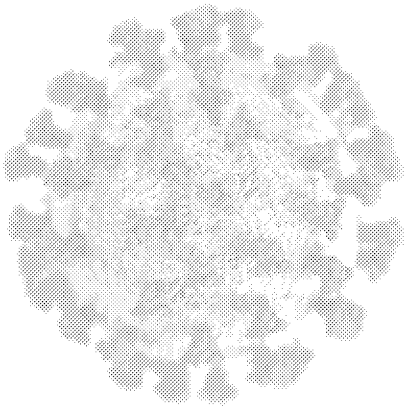
CDC Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again

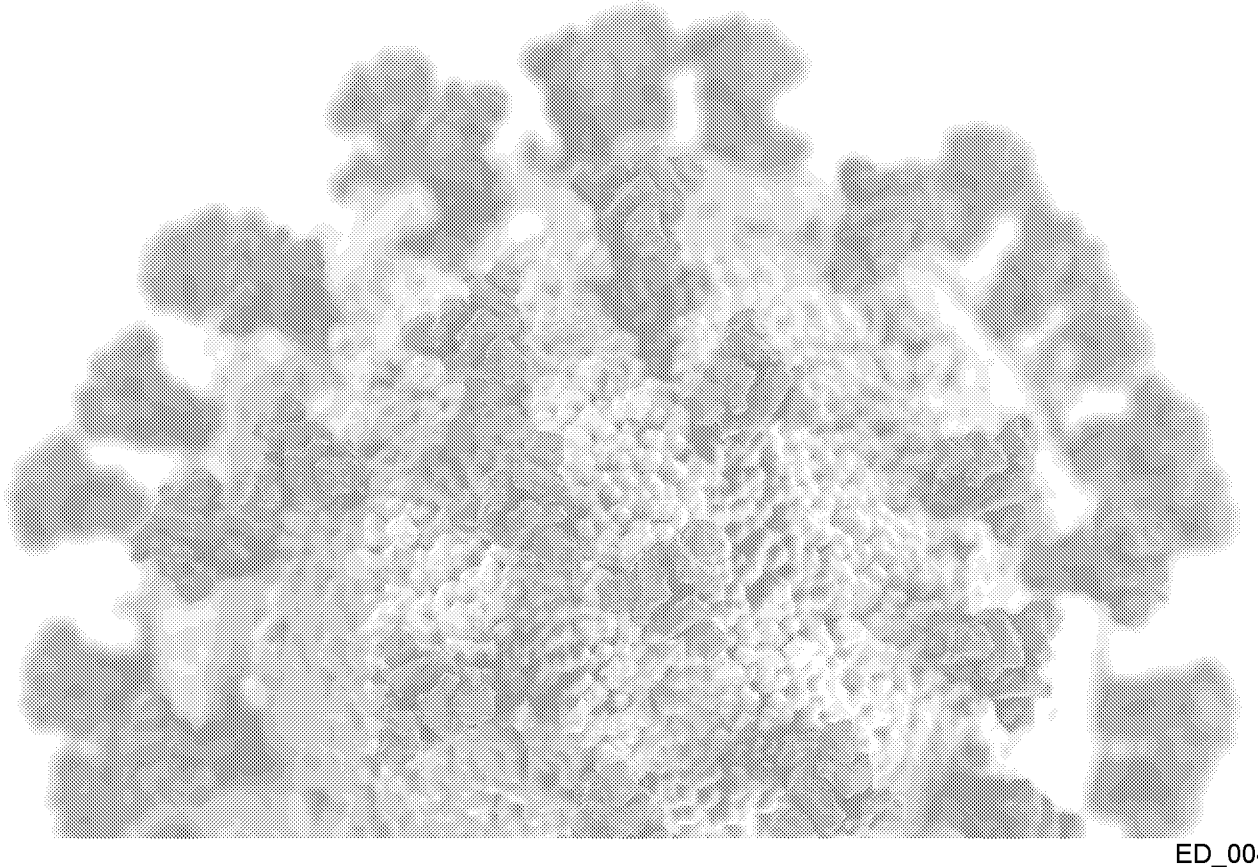


May 2020

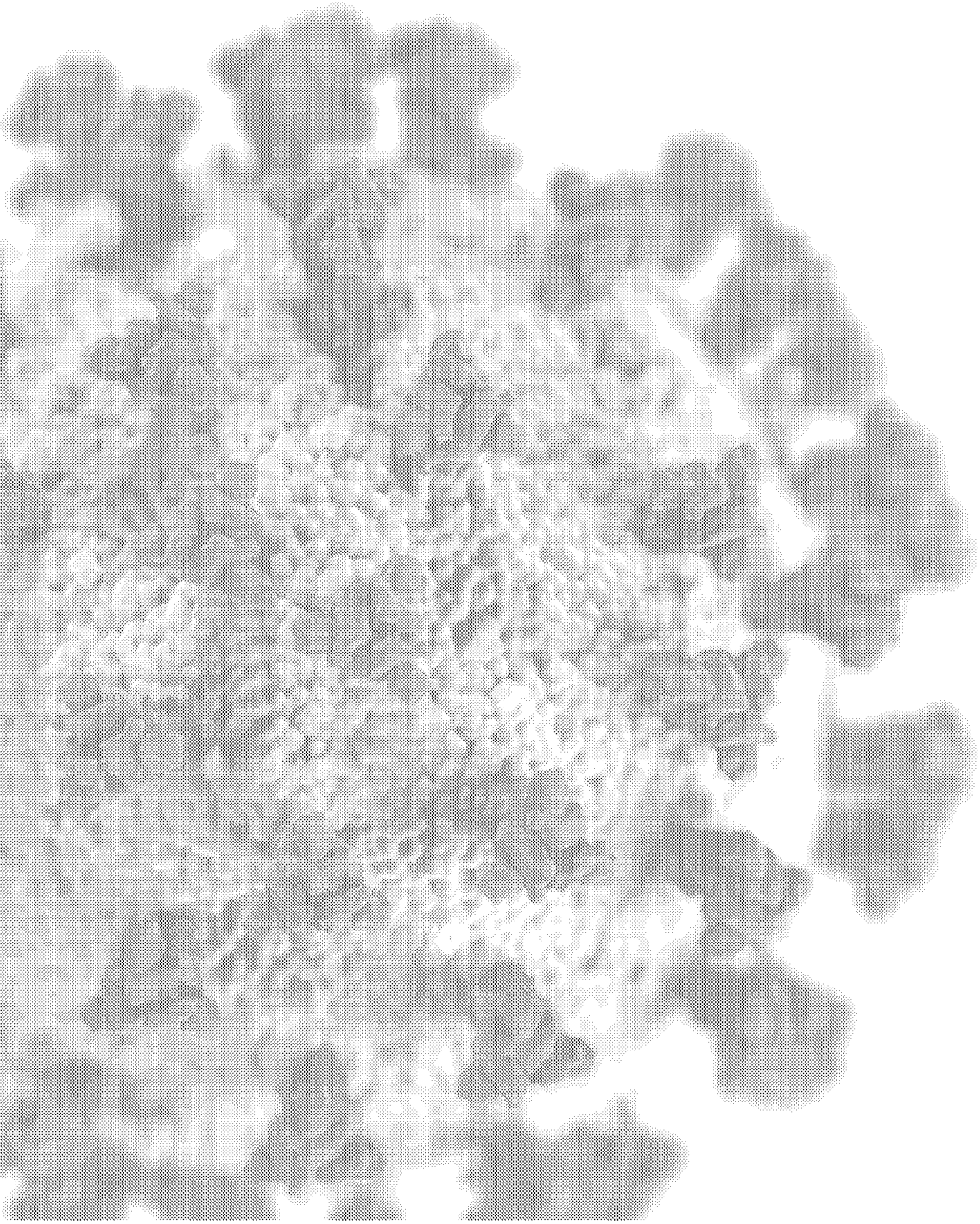
U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention







Contents



This document briefly summarizes CDC's initiatives, activities, and tools in support of the Whole-of-Government response to COVID-19.

Overview of CDC's Surveillance and Control Goals and Activities

The principal objectives of COVID-19 surveillance are to monitor the spread and intensity of the pandemic, to enable contact tracing to slow transmission, and to identify disease clusters requiring special intervention. Secondary objectives include understanding the severity and spectrum of disease, identifying risk factors for and methods of preventing infection, and producing data essential for forecasting. In addition to tracking the disease itself, monitoring of healthcare capacity and essential supplies through the National Healthcare Safety Network (NHSN) is critical to ensure adequacy of care.

Because no single system can capture all parameters of the pandemic, CDC has implemented multiple, complementary surveillance systems (Appendix A). Key systems are case-based reporting through the National Notifiable Diseases Surveillance System (NNDSS), laboratory-based surveillance, syndromic-surveillance data reported through the National Syndromic Surveillance Program (NSSP), and data on healthcare system capacity reported through the NHSN (Appendix B). Additional systems, such as COVID-Net, provide rich, publicly available information for meeting secondary objectives. CDC continues to explore emerging and experimental surveillance platforms with a critical eye toward proven utility.

Control of the epidemic requires action at the individual, community, and population levels. CDC has provided state, tribal, local, and territorial health departments with extensive detailed guidance on contact tracing, infection control, and a wide range of other prevention and control topics. Recent models suggest that asymptomatic and pre-symptomatic transmission and delays in case recognition can greatly reduce the effectiveness of contact tracing. To enhance the speed and thus effectiveness of contact tracing, CDC is exploring technologic methods for instantaneous voluntary notification of contacts of confirmed cases.

At the community level, recent events have shown the devastating effects that outbreaks can have among vulnerable populations, especially those in congregate settings such as nursing homes, prisons, and homeless shelters. Similarly, outbreaks in food production plants and other critical industries are crippling communities financially and threatening national food security. Rapid identification and response to these events is a CDC priority that can mitigate the immediate impact and provide critical insights needed to prevent future outbreaks in similar settings. CDC has developed extensive tools to assist states, counties, facilities, and industries in responding to and preventing these events (Appendix C).

Laboratory testing of asymptomatic individuals is an evolving consideration as more is learned about the role of asymptomatic and subclinical infections in transmission SARS-COV-2. Emerging evidence suggests that asymptomatic infections may play an important role in the epidemiology of the disease. However, it is important to define the circumstances where testing asymptomatic persons is likely to be helpful in controlling the COVID-19 pandemic. Interim guidance about laboratory test usage for asymptomatic populations and for serologic testing and serologic surveillance is provided in Appendix D.

Surveillance and hospitalization indicators can aid public health and government officials in their decisions when to reopen communities. The disease occurrence and hospital gating indicators in the Opening Up America Again guideline provide states and communities insight into the trajectory of the COVID-19 pandemic in their jurisdiction. These indicators are part of the broad assessment jurisdictions should undertake when deciding when and how to adjust community mitigation strategies for COVID-19 (Appendix E).

As businesses and other organizations gradually open after the COVID-19-related slowdown, they will need to consider a variety of measures for keeping people safe. These considerations include practices for scaling up operations, safety actions (e.g., cleaning and disinfection, social distancing), monitoring possible reemergence of illness, and maintaining health operations. Interim guidance for helping establishments with these steps is provided in Appendix F.

Widespread community mitigation combined with ongoing containment activities represents both an effective intervention for limiting the spread of COVID-19 and a serious threat to the economic well-being of the country and the world.

CRITICAL INITIATIVES AND ACTIVITIES

A. Expanding Testing and Advising Testing Practices

Extensive, rapid, and widely available COVID-19 testing is essential. CDC is working within the "All-of-Government and All-of-America Approach" to increase testing capacity and availability to improve case detection and contact tracing though all phases of the US plan to Opening Up America Again. As the supply and nature of tests expand, testing criteria have been broadened to include a wider range of people and situations.

Prioritizing Patients for Testing: Current recommendations for testing: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

Focusing Testing Efforts: CDC is working across the US government to support diverse efforts to increase testing in multiple settings to support diagnosis, surveillance, and outbreak control:

- **Testing for Diagnosis and Clinical Management:** CDC is working with federal government partners to support hospitals, healthcare systems, clinics, and public health departments to ensure the capability to diagnose COVID-19 infections with a turnaround time needed for appropriate clinical care and public health decision-making. CDC is:
  - » Working with federal government partners to provide a wide range of technical assistance resources to each state to help them develop a state-specific testing plan that meets their unique needs.
  - » Equipping state public health laboratories with sufficient quantities of devices, reagents, and testing supplies in the International Reagent Resource (IRR).
  - » Working with the White House Coronavirus Task Force to enhance the national supply of reagents and testing supplies so that the commercial market is able to supply state efforts. This supply should be sufficient to achieve a rate of less than 10% positive tests for COVID-19 among symptomatic, asymptomatic, and pre-symptomatic individuals.
- **Testing for Surveillance and Outbreak Control:** Identify newly emergent cases or clusters of COVID-19 among symptomatic and asymptomatic individuals who are prioritized by public health officials and clinicians, and improve reporting of COVID-19 cases to public health systems. CDC is:
  - » Utilizing established, nationwide surveillance systems to identify any areas of potential COVID-19 outbreaks, including use of CDC's Influenza-Like Illness Network and the National Syndromic Surveillance Program.
  - » Enabling public health systems at state, local, territorial, and tribal levels to develop a robust system to identify COVID-19 infections, particularly among vulnerable populations such as residents of nursing homes, people of racial and ethnic minority groups (e.g., African Americans, American Indians, Alaska Natives) at higher risk of disease, and those in areas of high social vulnerability, closed settings, and congregate housing.
  - » Supporting existing case-based surveillance efforts for identifying infections through routine testing of persons in clinical encounters.
  - » Enhancing case investigation and contact tracing efforts through increased public health staff and rapid testing capability.
  - » Working with point-of-care diagnostic test manufacturers and state health departments to improve reporting of results from rapid, point-of-care devices
  - » Evaluating various serologic assays for use in surveillance and for potential use for returning to work.

Defining Usage: CDC is working with state, local, and other partners to define the circumstances where testing of asymptomatic persons is likely to be helpful in controlling the pandemic, as well as the best application of surveillance serologic testing.

- Emerging evidence suggests that asymptomatic infections play an important role in the epidemiology of SAR-CoV-2 infections. Testing for asymptomatic infection should focus (1) on persons with an increased likelihood of infection and (2) on settings with particularly vulnerable populations.
- CDC is working to identify indications for serologic testing. Broadly, the purpose of serologic test falls into two categories: serologic surveillance of populations and serologic testing of individuals to determine if they have had a prior infection. This current CDC COVID-19 test is not currently designed for individual use (i.e., to test people who want to know if they have been previously infected with SARS-CoV-2). Serologic surveillance has the potential to provide important insights into the transmission dynamics of disease, as well as a more complete picture of total burden of COVID-19 infections in a community or among first responders and front-line health providers. More information is needed to determine how the results of serologic testing correlate with possible immunity.
- See Appendix D and https://www.cdc.gov/coronavirus/2019-ncov/lab/serology-testing.html for additional details on testing strategies, testing of asymptomatic infections, and serologic testing.

Augmenting Existing Infrastructure and Technology to Improve Data Flow and Reporting:

CDC is supporting the improvement of current data infrastructure, and the development and integration of digital/technology solutions to augment state and community-wide sites to ensure timely and transparent communication to all citizens inclusive of daily new cases, hospitalizations, use of intensive care units (ICU), and mortality by county and or zip code. To ensure geographic relevant information is continuously available to state and local governments and the public in those communities, this should also include laboratory and potential immunization data systems. Activities include:

- Working with state and local officials and web development groups to develop and support interactive web-based platforms that allow open and transparent data visibility to all communities, such as the Florida Public Health COVID-19 website.
- Working with manufacturers for point-of-care diagnostic tests, commercial laboratories, state and local health departments, testing locations (providers, hospitals, pharmacies), and public health partners (Association of Public Health Laboratories [APHL], Council of state and Territorial Epidemiologists [CSTE]) to improve data quality, integration, and electronic reporting.
- Developing, integrating, and testing the ability for laboratories to securely share data with digital platforms selected by public health, including platforms that may be used for testing, or to support state and local contract tracing.
- Exploring digital solutions to share laboratory results with patients directly and sharing tested best practices with state and local partners. This could also extend to immunization record access.
- Developing recommendations for minimum requirements of platforms to integrate, store, and manage personal laboratory information on digital platforms (what states should consider before investing or having additional standards for platforms handling these data).

B. Phased Plan and Indicators for Reopening America

The plan for reopening America outlines a three-phased approach for reducing community mitigation measures while protecting vulnerable populations. The phased approach can be implemented statewide or community-by-community at governors' discretion. The guidelines propose the use of six "gating" indicators to assess when to move through from one mitigation phase to another.

Table 1. Gating Criteria and Phase-specific Thresholds

Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in newly identified COVID-19 cases	Downward trajectory (or near-zero incidence) of documented cases over a 14-day period	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days *after entering Phase 1*	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days *after entering Phase* 2
Decreases in emergency department (ED) and/or outpatient visits for COVID-like illness (CLI)	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported over a 14-day period	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported for at least 14 days *after entering Phase 1*	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported for at least an additional 14 days *after entering Phase 2*
Decreases in ED and/ or outpatient visits for influenza-like illness (ILI)	Downward trajectory (or near-zero incidence) of ILI reported over a 14-day period	Downward trajectory (or near-zero incidence) of ILI reported for at least 14 days *after entering Phase 1*	Downward trajectory (or near-zero incidence) of ILI reported for at least an additional 14 days *after entering Phase 2*
Decreases in percentage of SARS-CoV-2 tests positive	Downward trajectory (or near-zero percent positive) of positive tests as a percentage of total tests over a 14-day period (flat or increasing volume of tests)	Downward trajectory (or near-zero percent positive) of positive tests as a percentage of total tests for 14 days *after entering Phase 1* (flat or increasing volume of tests)	Downward trajectory (or near-zero percent positive) of positive tests as a percentage of total tests for at least 14 days *after entering Phase 2* (flat or increasing volume of tests)
Treat all patients without crisis care	Jurisdiction inpatient & ICU beds <80% full Staff shortage in last week = no PPE supplies adequate for >4 days	Jurisdiction inpatient & ICU beds <75% full Staff shortage in last week = no PPE supplies adequate for >4 days	Jurisdiction inpatient & ICU beds <70% full Staff shortage in last week = no PPE supplies adequate for >15 days
Robust testing program	Test availability such that percentage of positive tests is ≤20% for 14 days Median time from test order to result is ≤4 days	Test availability such that percentage of positive tests is ≤15% for 14 days Median time from test order to result is ≤3 days	Test availability such that the percentage of positive tests is ≤10% for 14 days Median time from test order to result is ≤2 days

Decisions to move between phases should also consider the public health capacity of the jurisdiction based on the criteria listed below. Other epidemiologic data sources available locally can be used to corroborate trends seen in core epidemiologic gating criteria. Special consideration should be given to infections identified in populations and settings such as healthcare personnel, patients in healthcare facilities (e.g., nursing homes, dialysis centers, long-term care facilities), and residents of congregate living settings (e.g., prisons, youth homes, shelters), underserved populations, and people of racial and ethnic minority groups (e.g., African Americans, American Indians, Alaska Natives) at higher risk of disease. Incidence and trajectory (increasing versus decreasing) of COVID-19 illnesses in the surrounding region should also be considered.

Table 2. Assessing Capacity for Case Identification, Follow Up, and Containment

Category	Considerations for Assessing Capacity for Case Identification, Follow Up, and Containment
SARS-CoV-2 testing in jurisdiction	Testing is available as indicated for clinical, public health, and infection prevention needs.
Identification of new COVID-19 cases	All new COVID-19 cases in the jurisdiction can be rapidly identified through active surveillance, including proactive monitoring for asymptomatic cases through surveillance monitoring.
Interviewing new COVID-19 cases	Initial interviews can be conducted for nearly all new COVID-19 cases within one day of health department notification.
Contact tracing	Follow up (isolation, self-monitoring, and rapid testing of selected contacts) can be initiated for nearly all identified contacts of newly identified cases.
Incidence relative to local public health resources	Public health capacity is sufficient to fully perform contact tracing and investigate outbreaks based on local incidence and resources available.

While some communities will progress sequentially through the reopening phases, there is the possibility of recrudescence in some areas. Given the potential for a rebound in the number of cases or level of community transmission, a low threshold for reinstating more stringent mitigation standards will be essential. The decision to reinstate community mitigation strategies will undoubtedly be very difficult and will require careful thought to define an evidence-based monitoring strategy and specific guidance for these decisions.

Technical Support for States

As part of the "Whole-of-Government" public health effort, CDC is providing states and other jurisdictions with technical assistance regarding testing, surveillance data collection and reporting, contact tracing, infection control, and outbreak investigation. Implementation of these activities is supported by the Paycheck Protection Program and Health Care Enhancement Act, which includes $11 billion to be awarded, within 30 days, directly to states, localities, territories, tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes to develop, purchase, administer, process, and analyze COVID-19 tests, conduct surveillance, trace contacts, and related activities. Listed below are additional strategies CDC is using to strengthen the capacity of state, tribal, local, and territorial (STLT) health departments to fight against COVID-19. This technical assistance is essential to ready the nation to re-open and minimize future COVID-19 outbreaks in jurisdictions across the country.

Contact Tracing

Contact tracing, a core disease control measure used by local and state health department personnel for decades, is a key strategy for preventing further spread of infectious diseases, including COVID-19. Contact tracing is part of the process of supporting affected individuals and warning contacts of exposure in order to stop chains of transmission. CDC is ramping up America's capacity to perform contact tracing. As part of this effort, CDC has developed multiple training tools for communities to train the newest frontline workers in public health. CDC will train newly identified contact tracers on how to quickly locate and talk with the affected individuals, assist with isolation issues, and work with affected individuals to identify people with whom the affected individuals have been in close contact. Identification of contacts will allow further outreach by public health to identify individuals who need to self-isolate.

Table 3. CDC Priorities and Strategies to Support STLT Health Departments

Priorities	Strategies
Contact tracing guidance and training https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/index.html	Provide CDC guidance on case investigation and contact tracing to STLT health departments Address key issues such as staffing and roles, when to initiate an investigation, steps to the investigation, confidentiality and consent, self-isolation, quarantine, and necessary support services (housing, food, medicine); data management; digital contact tracing tools and technology; and evaluation and monitoring • Work with states to develop a comprehensive proactive plan for the identification of asymptomatic case in areas of high vulnerability and/or high rates of co-morbidities
Address surge staffing needs https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/response-corps.html	Use a multi-pronged approach to enhance and complement the efforts of STLT health department staff through innovative hiring mechanisms designed to address the surge staffing needs of STLT health departments. Provide access to a variety of mechanism to complement local efforts to increase capacity. • Realign existing CDC field staff • Deploy CDC teams to address outbreaks in special settings • Partner with CDC Foundation and other organizations to place surge staff for STLT health departments across the nation • Partner with other federal agencies (e.g., AmeriCorps) to offer staffing options with states • Facilitate access to a variety of contact tracing and case investigation training products and tools for a diverse and evolving public health workforce

Continued on the next page ▶

Priorities	Strategies
Innovative technologies	Support implementation of innovative methods and technologies at the STLT levels to help inform and guide the national response. • Develop guidance for assisting states and locals in evaluating tools, refining guidance, and identifying gaps in contact tracing workflow • Leverage partnerships to facilitate information sharing among our state and local partners regarding digital contact tracing tools • Share the landscape of digital tools, including those for contact tracing, case management, workforce management, and proximity tracking

Conclusion

As part of the Whole-of-Government Response, CDC has developed and is continually evaluating and improving the comprehensive surveillance program to generate essential data for tracking the pandemic and guiding the overall response to COVID-19. In addition, CDC is working with federal, state, and local partners to improve testing and to advise and support communities during the phased reopening of America.

Appendix A: Surveillance for COVID-19

The goals of US surveillance are to produce timely and accurate information at national, state, local and community levels to inform decisions on public measures for implementing and adjusting disease reduction strategies, to guide clinical decisions, to educate the public and key stakeholders, and to provide data for estimating and forecasting disease burden.

Surveillance Objectives

- To identify both symptomatic and asymptomatic/presymptomatic cases and track contacts to slow transmission of COVID-19 in the United States
- To monitor spread and intensity of COVID-19 disease in the United States
- To understand disease severity and spectrum of illness
- To understand risk factors for severe disease and transmission
- To monitor for virus changes
- To estimate disease burden
- To produce data for forecasting spread and impact
- To identify when thresholds have been met to adjust community mitigation measures

Approach

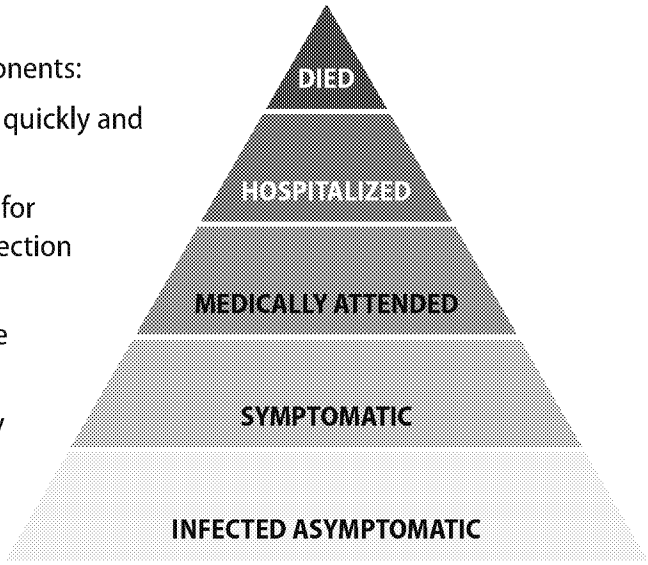
Using multiple surveillance systems and epidemiology networks, CDC in collaboration with state, local, and academic partners, monitors the progression and impact of COVID-19 spread in the United States. The combination of data from the different systems is used to generate an ongoing picture of virus spread and produce data to address the key questions for directing and refining the US response. Surveillance data are used for:

- *Situational awareness*—Timely monitoring of the spread and intensity of COVID-19 disease in the United States. Surveillance systems allow for efficient targeting of public health measures, developing timely communications, and preparing health systems for increasing numbers of ill people. Data from these systems will be updated daily or weekly to create an ongoing, accurate understanding of impacted regions, affected populations, trends over time, and viral characteristics.
- *Understanding impact and forecasting disease spread*—All surveillance systems will be employed to produce data to understand overall impact and epidemic characteristics to inform future use of public health and medical resources.
- *Characterizing COVID-19 infection* across a spectrum of conditions include:
  - » asymptomatic infections
  - » symptomatic infection
  - » medically attended outpatient and ambulatory visits
  - » hospitalizations
  - » deaths

Operational Plan

The plan is operationalized according to the following components:

- Increase laboratory testing and reporting to detect cases quickly and reliably for timely public health action
- Use robust syndromic surveillance, proactive monitoring for asymptomatic cases in settings with people at risk for infection or with known vulnerabilities
- Use laboratory reporting systems to monitor local disease trends to identify if thresholds (gates) have been met
- Corroborate trends and risk assessment with high-quality data from sentinel surveillance and systems
- Monitor disease and outbreaks in healthcare, institutional, workplace and group settings



- Use data for estimation of disease burden over time and to aid disease and transmission forecasts

Federal, State, and Local roles

The surveillance strategies rely on collaboration at federal, state, and local levels. The federal government will work with the states to establish the data platforms used by states and local jurisdictions to monitor transmission, public health, and health system capacity and provide technical assistance and coordination of information sharing and decision making across jurisdictions. These data platforms will be public facing to maximize transparency and maximize information to communities at the most granular level. Using the federal data systems, states can share data and information and communicate with residents' decisions under consideration and clear guidance on adhering to mitigation levels. In addition to implementing federal programs, states can also coordinate resource allocation within their regions and across communities and monitor indicators closely to make decisive adjustments to mitigation measures. Finally, local governments are responsible for feeding data and information into state and federal data systems and adjoining communities.

Components of the US COVID-19 surveillance plan

The surveillance program is built on a combination of existing influenza and viral respiratory diseases surveillance systems, syndromic surveillance systems, case reporting systems, proactive monitoring for asymptomatic cases in areas of demonstrated vulnerabilities, commercial laboratory reporting, ongoing research platforms employed for the COVID-19 response, and new systems. The systems are summarized in Table 4 and a more fully described in Appendix A.

Table 4. Surveillance Systems Used by Objective.

Surveillance data for decision-making uses multiple systems and epidemiology networks. These approaches use laboratory submitted specimens, electronically transmitted data, and other sources to generate an ongoing picture of disease spread, intensity, and severity, and produce data to address the key questions for directing and refining the US response.

Goal addressed	Outcome	Platform
Trends in disease spread and intensity	No. of cases, by location, trends, demographics, underlying diseases, outcomes	COVID-19 case-based surveillance
	No. of lab-positives; % positive, by age groups, location, over time	Public Health Laboratories (PHLs)
		National Respiratory and Enteric Virus Surveillance System (NREVSS)
		Commercial labs
	Outpatient, syndromic—%ILI, trends in ILI by region, age group, concordance and discordance between surveillance data	ILInet
		National Syndromic Surveillance Program (NSSP)
	Outpatient—laboratory-confirmed, % positive, by location, by age group	Laboratory-confirmed outpatient (OP) surveillance
		US Flu Vaccine Effectiveness (VE) network (acute respiratory illness)
Severity/clinical spectrum	Hospitalizations rates, by age group, underlying condition	FluSurvnet—all ages
	Hospitalizations	New Vaccine Surveillance Network (NVSN)—pediatrics
Viral changes	Virus characterization, sequence changes	PHLs and CDC/DVD SPHERES
Risk factors for severe disease	Risk of severe disease given underlying illness, age	COVID-19 case-based surveillance
		US Flu VE network
		FluSurvnet—all ages
		NVSN—pediatrics
		Hospitalized Adult Influenza Vaccine Effectiveness Network (HAIVEN)
		Influenza ICU Vaccine Effectiveness Study
		Pediatric Intensive Care Influenza Network (PICFLU)
Disease burden	Overall number of persons affected by severity and age	All systems, plus additional special research studies
		Serologic surveys
Pandemic severity	Pandemic Influenza Severity Assessment (PISA)	Modeling based on epidemiological inputs

Continued on the next page ▸

Goal addressed	Outcome	Platform
Forecasting and modeling spread and impact	When will it peak, how many disease outcomes, how will it spread	Modelling work with broad coalition of modelers led by CDC, using data above
Transmissibility	Attack rates and risk factors for transmission	Field studies
		Flu Transmission Evaluation Study (FLuTES)
		Household Influenza Vaccine Effectiveness Study (HIVES)
Risk Factors for Severe disease	Risk of severe disease given underlying illness, age	Pandemic cohorts (community, households, healthcare workers, pregnant woman, long-term care facilities)
Disease Burden	Overall number of persons affected by severity and age	All systems, plus additional special research studies
		Serologic surveys
Pandemic Severity	PISA	Modeling based on Epi inputs
Forecasting and modeling spread and impact	When will it peak, how many disease outcomes, how will it spread	Modelling work with broad coalition of modelers led by CDC, using data above
Transmissibility	Attack rates and risk factors for transmission	Field studies
		FLuTES
		HIVE
		Pandemic cohorts (community, households, HCWs, pregnant woman, LTCFs)

Appendix B: Healthcare System Surveillance

Rationale and Objective

Measuring and reporting the impact of COVID-19 on the capacity of the US healthcare system—including both acute-care hospitals and long-term care facilities—is an essential public health function in the pandemic response and in plans for Opening Up America Again. To make critical decisions, all levels of government, including federal, regional, state, local, tribal, and territorial, and the healthcare system need detailed and timely information about the availability and shortages of key resources, including hospital beds, intensive care unit (ICU) beds, ventilators, personal protective equipment, and healthcare personnel shortages. Reporting needs to be comprehensive across all states.

Regional variations in disease burden place a premium on supporting a surveillance system that can provide standardized data that are timely, easy to interpret, and readily accessible for multiple end users at all geographic levels. Among the main objectives for a national healthcare surveillance system in the current crisis are providing timely and readily available metrics with which to monitor the pandemic's trajectory and progress toward Opening Up America Again. The key surveillance metrics available from NHSN are reported counts and a panel of additional summary statistics on hospitalized COVID-19 patients, hospital bed capacity, intensive care unit bed capacity, ventilatory capacity, supplies of personal protective equipment, and staffing shortages. These metrics, produced daily, serve as indicators that can drive decisions and actions at the national, state, county, tribal, territorial, and healthcare facility levels but needs to be expanded to be inclusive of all hospitals.

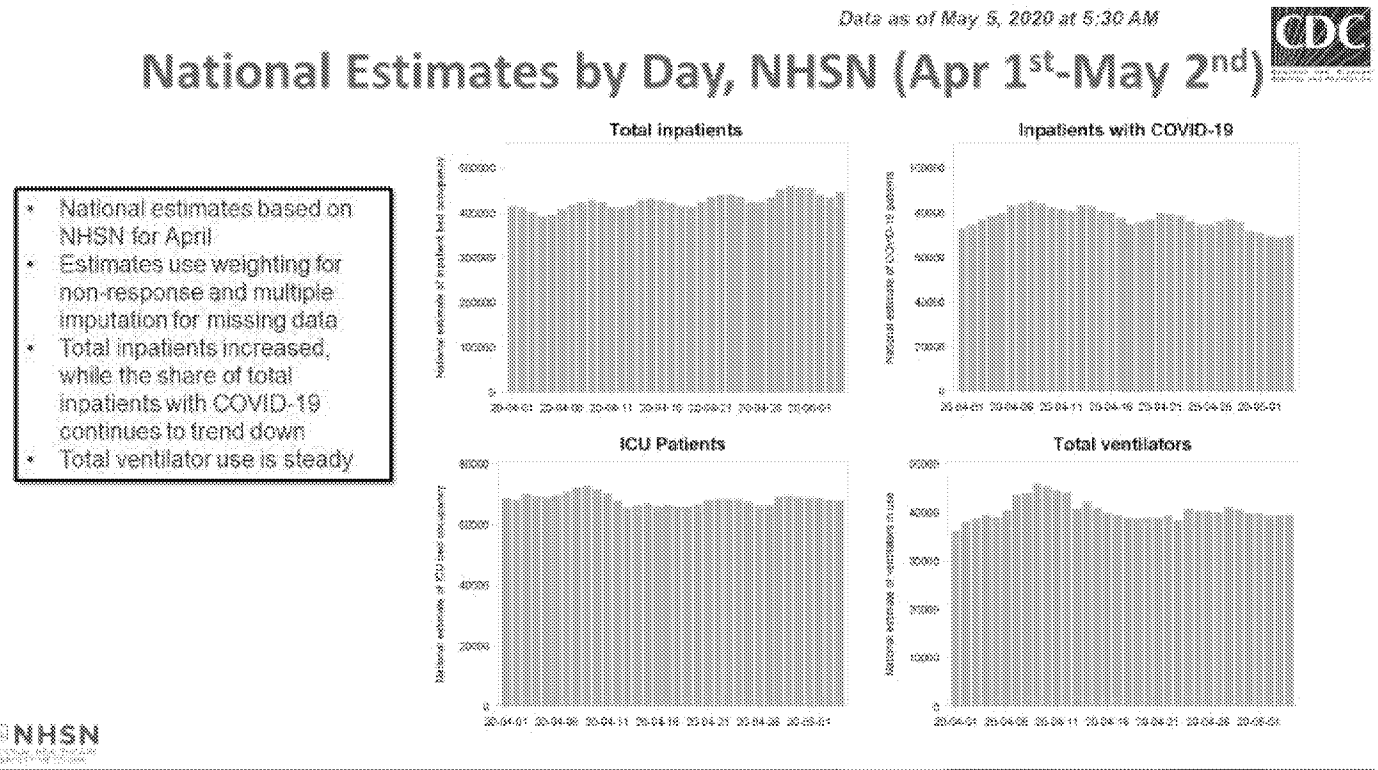
Key System

Implementation of several key surveillance metrics for monitoring the impact of the pandemic on the healthcare system are available through the existing Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN). NHSN's role as a shared platform for healthcare-associated condition surveillance provides a powerful and unique foundation for COVID-19 surveillance.

CDC is already efficiently leveraging NHSN—which was launched in 2005 and now is the nation's most widely used healthcare-associated condition tracking system—to support the nation's COVID-19 response. NHSN provides a well-established technical infrastructure, readily extensible platform, and a strong set of partnerships with healthcare facilities, state and local health departments, the Centers for Medicare and Medicaid Services (CMS), and electronic health record system (EHRs) companies, and other healthcare information technology suppliers. This system will need to continue improving to ensure 100% reporting of all cases and outcomes.

The US healthcare system relies on NHSN to track healthcare-associated conditions, improve patient safety, fulfill mandatory federal and state reporting requirements, and ultimately eliminate healthcare-associated conditions. NHSN serves as the operating system for hospital-associated infection reporting through legislation established by 36 states, Washington, D.C., and Philadelphia, PA. NHSN will need to be expanded to all states and all hospitals to provide a comprehensive analysis of COVID-19. CMS uses NHSN reporting to enable healthcare facilities to fulfill CMS requirements for submitting healthcare outcome data that are used in CMS's public reporting and incentive payment programs. Currently, over 25,000 healthcare facilities, including almost every hospital in the nation, more than 7,500 dialysis facilities, and over 3,000 nursing homes participate in NHSN. To be effective, this system must be nationwide and be comprehensive in reporting. Personnel in these facilities have extensive experience submitting data to NHSN, adhering to the system's surveillance protocols, and using their own data and national benchmarks provided by NHSN for local prevention and control purposes. NHSN's collaborations with EHR companies, infection surveillance system providers, and the Health Level Seven (HL7) data standards organizations enable healthcare facilities to submit data electronically to NHSN by using HL7 data exchange specifications.

On March 27, 2020, CDC launched the NHSN COVID-19 Patient Impact and Hospital Capacity Module (https://www.cdc.gov/nhsn/covid19/report-patient-impact.html), and as of April 24, 2020, over 56% of acute care hospitals and over 53% of critical access hospitals have reported COVID-19 surveillance metrics. This level of participation needs to continue to improve until reporting is at the 95–100% range. Additionally, as of April 28, 2020, all ~15,000 nursing homes will be required to report COVID-19 cases and deaths, as well as staffing and personal protective equipment supply metrics, to NHSN (https://www.cdc.gov/nhsn/ltc/covid19/index.html) per a new CMS Interim Final Rule. The adaptation of NHSN to the immediate needs of the emergency response is a clear example of how CDC is retooling, modernizing, and updating its existing national surveillance capabilities to confront the pandemic.

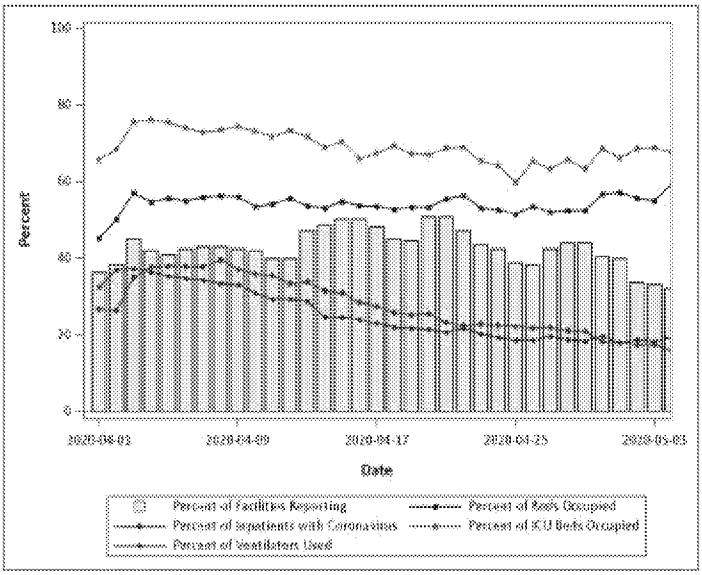


During the COVID-19 pandemic, data on key metrics are submitted daily to NHSN, where the data are analyzed daily and presented out to the key components at all levels of the public health response. NHSN COVID-19 data are an integrally important asset in the US government response. The NHSN data are provisioned for use in secure access systems maintained by the White House Coronavirus Task Force, the National Response Coordination Center (NRCC), CDC, FEMA, ASPR, and CMS. In addition, all state health departments, several local health departments, and many HHS ASPR and FEMA Regional Offices receive data from NHSN and rely upon it for regional and state emergency response decisions.

NHSN uses COVID-19 data to develop and report national and state-wide estimates that serve as indicators of stress on the healthcare system. Figures below show examples of national trend-data as well as an example of a state trend.

Data as of May 5, 2020 at 5:30 AM

NHSN Daily Crude Percent Occupancy, Louisiana



NHSN

Appendix C: Guidance on Infection Control and Contact Tracing

General CDC Guidance Hub https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance-list.html?Sort=Date%3A%3Adesc

Infection Prevention Control

- **What CDC is doing for infection control**
  - » https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
- **Standard CDC guidance on infection control in healthcare settings**
  - » Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
- **Best practices currently in use by states and private sector**
- **Link to virtual training**
  - » Training for Healthcare Professionals (including clinical care and infection control, PPE, nonpharmaceutical interventions, emergency preparedness and response, and additional topics): https://www.cdc.gov/coronavirus/2019-ncov/hcp/training.html
  - » Preparing Nursing Homes and Assisted Living Facilities for COVID-19 (CDC webinar): https://www.youtube.com/watch?v=p1FiVFx5O78
- **Focus areas/congregate settings:**
  - » Long-term care facilities
    - › Preparing for COVID-19: Long-term Care Facilities, Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
  - » Assisted living facilities
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
  - » Dialysis facilities
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/dialysis.html
  - » Dental facilities
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/dental-settings.html
  - » Ambulatory care facilities
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/ambulatory-care-settings.html
  - » Pharmacies
    - › https://www.cdc.gov/coronavirus/2019-ncov/healthcare-resources/pharmacies.html
  - » Emergency Medical Services (EMS)
    - › https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html
  - » Food processing facilities
    - › Meat and Poultry Processing Workers and Employers: Interim Guidance from CDC and the Occupational Safety and Health Administration (OSHA)
    - › https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html

- » Correctional facilities
  - › Resources for Correctional and Detention Facilities: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.
- » Businesses
  - › Interim Guidance for Businesses and Employers to Plan and Respond to Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html
  - › Prepare your Small Business and Employees for the Effects of COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-small-business.html

- **Other IPC tools/Resources:**
  - » IPC FAQs: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html
  - » Using PPE, including donning & doffing resources: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html
  - » Healthcare preparedness tools: https://www.cdc.gov/coronavirus/2019-ncov/hcp/preparedness-checklists.html
  - » Strategies to mitigate staffing shortages: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
  - » Key strategies to prepare LTCFs: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html
    - › LTCF Letter to residents, family members and visitors: https://www.cdc.gov/coronavirus/2019-ncov/downloads/healthcare-facilities/Long-Term-Care-letter.pdf
  - » Cleaning and disinfecting school and community facilities: https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html
- **Cleaning and disinfecting non-emergency transport vehicles:** https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/disinfecting-transport-vehicles.html
- **External partners tools/resources**
  - » **Centers for Medicare & Medicaid—COVID partner toolkit**—https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit
  - » **American College of Emergency Physicians**—Field guide—https://www.acep.org/corona/covid-19-field-guide/cover-page/
  - » **American Academy of Pediatrics**—Guidance for Telehealth Payer Policy in Response to Covid-19 https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/aap-guidance-telehealth-payer-policy-in-response-to-covid-19/
  - » **Society for Critical Care Medicine**—COVID-19 Resource Center—Includes literature and training https://www.sccm.org/COVID19RapidResources/Home
  - » **Society for Healthcare Epidemiology of America**
    - › COVID-19 Resource Page: http://shea-online.org/index.php/practice-resources/priority-topics/emerging-pathogens/novel-coronavirus-2019-2019-ncov-resources
    - › Hospital epidemiology training—https://learningce.shea-online.org/content/sheacdc-outbreak-response-training-program-ortp#group-tabs-node-course-default1/index.php
    - › Rapid Response Program podcast and webinar series https://learningce.shea-online.org/content/novel-coronavirus-covid-19

- » **Association for Professionals in Infection Control and Epidemiology**
  - › COVID-19 Page: https://apic.org/covid19/
  - › LTC text chapters: https://apic.org/resources/apic-text/apic-text-chapter-collection-long-term-care/
- » **American Medical Association, Resource Center for Physicians**—https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians
- » **American Nurses Association Resource Center**—https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus/?utm_campaign=261605+COVID-19+MKT&utm_source=hero&utm_medium=digitalad&utm_content=covidresourcepage
- » **American Dental Association**—COVID-19 Center—https://success.ada.org/en/practice-management/patients/infectious-diseases-2019-novel-coronavirus?utm_source=cpsorg&utm_medium=covid-nav&utm_content=nav-covid-19-center&utm_campaign=covid-19
- » **Argentum (senior living)**—Toolkit—https://www.argentum.org/coronavirustoolkit/

- **Critical infrastructure workers**
  - » Implementing Safety Practices for Critical Infrastructure Workers Who May Have Had Exposure to a Person with Suspected or Confirmed COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html
  - » Transportation and Delivery Workers:
    - › https://www.cdc.gov/coronavirus/2019-ncov/community/transportation/index.html
  - » Airport, Airline Workers
    - › What Airline Customer Service Representatives and Gate Agents Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/airport-customer-factsheet.html
    - › What Airport Baggage and Cargo Handlers Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-baggage-cargo-handlers.html
    - › What Airport Custodial Staff Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-custodial-staff.html
    - › What Airport Passenger Assistance Workers Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/airport-passenger-assistance-workers.html
    - › What Aircraft Maintenance Workers Need to Know about COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/aircraft-maintenance-workers.html
  - » Other transit workers:
    - › What Bus Transit Operators Need to Know About COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/bus-transit-operator.html
    - › What Rail Transit Operators Need to Know About COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/rail-transit-operator.html
    - › What Transit Maintenance Workers Need to Know About COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/transit-maintenance-worker.html
    - › What Transit Station Workers Need to Know About COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/transit-station-workers.html
  - » Occupational Safety and Health Administration resources
    - › Control and Prevention: https://www.osha.gov/SLTC/covid-19/controlprevention.html
  - » Guidance on Preparing Workplaces for COVID-19: https://www.osha.gov/Publications/OSHA3990.pdf

- **Return to work**
  - » Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
- **PPE reuse guidance**
  - » Strategies to Optimize the Supply of PPE and Equipment (including eye protection, isolation gowns, facemasks, N95 respirators, elastomeric respirators, and ventilators): https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
  - » Decontamination and Reuse of Filtering Facepiece Respirators: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html
  - » Personal Protective Equipment (PPE) Burn Rate Calculator: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html
- **Sustainable Isolation**
  - » Interim Infection Control Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings at https://www.cdc.gov/coronavirus/2019-ncov/php/guidance-evaluating-pui.html
  - » Public Health Guidance for Potential COVID-19 Exposure Associated with International Travel or Cruise Travel at https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html
  - » Public Health Recommendations for Community-Related Exposure at https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html
  - » Links to programs to support people in isolation: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/index.html
  - » Links to housing support for people without safe places for isolation: https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html
  - » Links to federal programs- unemployment etc.
  - » www.coronavirus.gov
  - » https://www.coronavirus.gov/smallbusiness/
  - » https://www.irs.gov/coronavirus-tax-relief-and-economic-impact-payments
  - » https://www.usa.gov/unemployment
- **Call center for clinical inquiries 24/7 (770-488-7100)**
  - » https://www.cdc.gov/cdc-info/ask-cdc.html
- **Others**
  - » NIH COVID-19 Treatment Guidelines: https://www.covid19treatmentguidelines.nih.gov/overview/
  - » Therapeutic options: https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html
  - » Infectious Diseases Society of America Guidelines: https://www.idsociety.org/practice-guideline/covid-19-guideline-treatment-and-management/
  - » Information for Pediatric Healthcare Providers: https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html
  - » Considerations for Inpatient Obstetric Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html
  - » Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

Contact Tracing

- **Contact Tracing Overview:** https://www.cdc.gov/coronavirus/2019-ncov/php/open-america/contact-tracing.html
- **Principles of Contact Tracing: Part of a Multipronged Approach to Fight the COVID-19 Pandemic**: https://www.cdc.gov/coronavirus/2019-ncov/php/principles-contact-tracing.html (also see PDF booklet: https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/principles-contact-tracing-booklet.pdf)
- **Sample Contact Tracing Training Plan:** https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/contact-tracing-training-plan.pdf
- **Digital Contract Tracing Tools for COVID-19:** https://www.cdc.gov/coronavirus/2019-ncov/downloads/digital-contact-tracing.pdf
- **Preliminary Criteria for the Evaluation of Digital Contact Tracing Tools for COVID-19:** https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/prelim-eval-criteria-digital-contact-tracing.pdf
- **External partners tools/resources**
  - » **Association of State and Territorial Health Officials:** Making Contact: A Training for COVID-19 Contact Tracers Introductory Online Course: https://learn.astho.org/p/ContactTracer
  - » **Johns Hopkins Bloomberg School of Public Health Center for Health Security:** Review of Mobile Application Technology to Enhance Contact Tracing Capacity for COVID-19 https://www.centerforhealthsecurity.org/resources/COVID-19/COVID-19-fact-sheets/200408-contact-tracing-factsheet.pdf
  - » **National Association of County & City Health Officials:** Building COVID-19 Contact Tracing Capacity in Health Departments to Support Reopening American Society Safely: https://www.naccho.org/uploads/full-width-images/Contact-Tracing-Statement-4-16-2020.pdf

Appendix D: Guidance on Test Usage (Asymptomatic Populations and Serology)

Information on testing prioritization can be found here: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

Testing asymptomatic populations

Testing of asymptomatic individuals is a growing consideration as the role of asymptomatic and subclinical infections in transmission becomes more apparent. Emerging evidence suggests that asymptomatic infections may play an important role in the epidemiology of the disease. Nevertheless, it is important to define the circumstances where testing asymptomatic persons is likely to be helpful in controlling the COVID-19 pandemic. Effective testing programs will focus on (1) persons with an increased likelihood of infection and (2) settings with particularly vulnerable populations, including but not limited to the following:

- Contacts of known (symptomatic or asymptomatic) cases. This may include testing of contacts going back one to two weeks before the onset of symptoms, particularly contacts who work with vulnerable populations.
- Residents and staff of long-term care facilities. Periodic testing and sentinel surveillance in these settings may serve to detect outbreaks early in this setting, where devastating outbreaks are known to occur and to be associated with high rates of asymptomatic infection. CDC is updating guidance for surveillance in these settings https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html.
- Other healthcare facility workers and first responders. Healthcare facilities may consider testing staff periodically, starting with staff in high traffic, high risk areas such as emergency departments.

Serologic testing

Serologic testing currently has little role in the diagnosis of acute disease but is already playing an important role in the response to the pandemic. The uses of serologic testing fall into two broad categories: serologic surveillance of populations and serologic testing of individuals for proof-of-prior infection.

Serologic surveillance

https://www.cdc.gov/coronavirus/2019-ncov/covid-data/serology-surveillance/index.html

Serologic surveillance has the potential to provide a more complete picture of how much infection has occurred already in the United States. Case-based surveillance for anything with a wide spectrum of severity will always miss many cases, and its increasingly clear that a substantial proportion of SARS-CoV-2 infections are asymptomatic. To the degree that SARS-CoV-2 infection results in measurable antibodies, serologic testing will pick up any infection.

The purposes of serologic surveillance are the following:

- To provide a more complete estimate of the incidence of infection.
- To determine the proportion of the population that was previously infected.
- To better understand transmission.
- To evaluate the impact of community mitigation measures.

CDC has published its COVID-19 Serology Surveillance Strategy at https://www.cdc.gov/coronavirus/2019-ncov/covid-data/serology-surveillance/index.html

External serosurveys

- CDC will support state, tribal, local, and territorial health authorities to plan and implement serosurveys in their populations with known prior exposure. Serial antibody tests, initial and confirmatory, will be used in all field studies to ensure enhanced positive predictive values.

Serologic testing of individuals for proof-of-prior infection (immunity)

https://www.cdc.gov/coronavirus/2019-ncov/testing/serology-overview.html

While the lay public often mistakenly refers to this as "serologic surveillance", it is fundamentally different and is at its core a clinical activity designed to guide decisions about specific individuals by determining whether or not they are already immune to the infection. Serologic testing may play a role in a back-to-work strategy provided it can be shown that serologic testing can reliably infer immunity. This immunity may not need to be absolute: protection against severe infection may be enough even if immunity against reinfection isn't reliable or durable.

While there appears to be considerable public optimism that serologic testing will allow return to work without the need for PPE or other precautions, there are many unknowns at this early date that limit implementation of serology for this purpose:

- The correlates of immunity to SARS-CoV-2 are not known and there are few or no data to confirm that antibodies detected in serologic tests correlate with such immunity. Studies in the US military during the 1970s showed that reinfection with endemic coronaviruses occurred in the presence of low levels of antibodies. Nonetheless, most experts feel immunity from infection is likely at least in the short term.
- The performance characteristics of serologic assays are not yet known, although there is much work ongoing to define those characteristics. Typically, a well-performing single step serologic assay may be expected to have a specificity of 95% (sensitivity is a secondary concern here, although also important), which is likely not enough for this purpose, given the potential consequences of COVID-19. Combining two different tests will be critical for improving performance and should be part of any strategy to utilize serologic testing for "immunity" determinations.
- The current seroprevalence is likely to be highly variable. In New York City, for example, with one of the highest incidence rates in the country, a recent survey among customers of retail outlets found a seroprevalence of 22%. Preliminary data at CDC from remainder clinical specimens in the New York City area found about half that rate; in Western Washington, the preliminary rate was closer to 5%. This has two implications:
- At best, the use of serologic testing for a back-to-work strategy would likely benefit fewer than 10% of the population currently.
- In the setting of a relatively low seroprevalence, any serologic test would have to have excellent performance characteristics. If a test with 95% specificity were used in a population with a true seroprevalence of 5%, almost half all "positives" would be false-positive and not immune and therefore must include 2 serial tests to confirm all positive results.
- There is a need for high-level consensus on the role of serologic testing in a back-to-work policy. The stakes are high for such a policy, so that in addition to the scientific data, there is also a need to have political consensus on this issue. Consensus is also needed on a plan for how to provide documentation of that immunity, be it through federal- or state-based immunity registries, digital proof-of-immunity, or physical documentation such as "immunity certificates".

Despite these limitations, continued interest in the use of serologic testing in a back-to-work policy is likely. In the meantime, CDC is doing the following:

- Working with NIH/NCI, FDA, and ASPR on evaluating the first panel of 25 serologic assays. More testing will quickly follow these tests.
- Designing studies to track healthcare workers long term to monitor for evidence of reinfection.
- Tracking seroprevalence nationally, as described above.

Appendix E: Assessing Surveillance and Hospital Gating Indicators

This document is for use by public health and government officials to aid their decisions when to reopen communities. It describes four indicators specific to disease occurrence and hospital readiness, which form part of the "gating criteria" described in the Opening Up America Again guidelines.

Background and Summary

On April 16, 2020, the White House released the Opening Up America Again guideline (https://www.whitehouse.gov/openingamerica/), which outlines a three-phased approach to relaxing community mitigation measures currently in place to limit transmission of the SARS-CoV-2 virus. The purpose of the guideline is to outline a path to re-opening the economy while mitigating the risk of resurgence in COVID-19 illnesses and protecting vulnerable populations. The phased approach can be implemented on a statewide basis or community-by-community at governors' discretion. The guideline proposes the use of three categories of "gating" indicators (based on symptoms, based on cases, and for hospitals) to assess when to move through three community mitigation phases (Phase One, Phase Two, and Phase Three). Two gating indicators are in each category and include:

- *Indicators based on symptoms:*
  1. Downward trajectory of influenza-like illnesses (ILI syndrome) reported within a 14-day period

     AND
  2. Downward trajectory of COVID-like syndromic cases (i.e., COVID-like illness or CLI syndrome) reported within a 14-day period
- *Indicators based on cases:*
  3. Downward trajectory of documented COVID-19 cases within a 14-day period

     OR
  4. Downward trajectory of positive tests as a percent of total tests within a 14-day period (concurrent with a flat or increasing volume of tests)
- *Indicators for hospital readiness:*
  5. Capacity to treat all patients without utilization of crisis care standards

     AND
  6. Robust testing program in place for at-risk healthcare workers, including antibody testing

The Table at the end of the section summarizes all six indicators and the measures to support planning for transitioning through community mitigation phases. Indicators 1 through 4 rely on public health surveillance data to determine the trajectory of COVID-19 transmission within a jurisdiction. This document describes the measurement and interpretation of these four disease occurrence gating indicators. This document also highlights other disease occurrence measures that may be important for state or local jurisdictions to use when adjusting the intensity of community mitigation measures. Indicators 5 and 6 utilize hospital readiness measures to inform decision-making processes about readiness to move through mitigation phases. In addition to these indicators, CDC and CMS work collaboratively to provide guidance for reopening America. Further information on reopening of clinical facilities is available at https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf.

Disease Occurrence Gating Indicators

The following subsections provide further detail for each of the disease occurrence gating indicators outlined in the Opening Up America Again guideline, including a description and rationale, potential data sources, how to assess decreases (and moving through the three mitigation phases), how to assess increases (i.e., "rebound"), and interpreting each measure's strengths and limitations. Numerous data sources and surveillance systems exist at the local, state, and federal levels that can be used to measure and evaluate these indicators. Local and state officials should use the best data available, regardless of source, when assessing the trajectory of COVID-19 illnesses. Variability will exist from jurisdiction to jurisdiction in the quality, completeness, and timeliness of these data sources, and sufficient data may not be available for all jurisdictions to evaluate all four of the disease occurrence gating criteria. In situations where all the gating indicators cannot be assessed, additional data sources available locally may assist in determining the trajectory of COVID-19 activity in the jurisdiction.

Downward trajectory of ILI reported within a 14-day period

- **Description/Rationale:** ILI is a syndromic surveillance categorization applied to emergency department (ED) and outpatient visit symptom and diagnostic code data. This measure is intended to identify areas that are experiencing sustained decreases in outpatient clinic or ED visits in people with ILI. ILI is defined as fever with cough and/or a sore throat. COVID-19 may present with symptoms similar to ILI, so the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) and the National Syndromic Surveillance Program (NSSP) can be used to track COVID-19 trends, especially when paired with SARS-CoV-2 and other respiratory pathogen testing data.
- **Data Sources:** Outpatient care facilities and hospital EDs selected by state and/or local health departments for participation in the Outpatient Influenza-Like Illness Network (ILINet) report to CDC either directly or through their health department via a web-based reporting system. In addition, electronic data, including data from CDC's NSSP can be uploaded to ILINet. These data are stored in a shared database for use by CDC and state/local public health officials. States and jurisdictions may collect syndromic surveillance data on ILI locally that is not submitted to ILINet but could be used in interpreting the ILI gating indicator. ILINet data is available publicly at the state-level at https://www.cdc.gov/flu/weekly/fluviewinteractive.htm.
- **Assessing Decreases:**
  - » To pass the criteria of a 14-day downward trajectory in ILI syndromic cases, a locality must either have experienced 14 days of decreasing cases or 14 days of minimal ILI activity. To determine a downward trajectory, the visits data are assessed using a smoothed curve to account for periodic fluctuations in ILI. To calculate this curve, CDC applies a cubic spline, or "smoothed curve", a statistical method that smooths out day-to-day variability in the data. The slope of this curve is used to assess declining incidence. Localities must have 14 days of consecutive downward slope, allowing for 2–3-day grace periods of increasing ILI to allow for irregularities. It is recommended that localities assess both the total counts of ILI visits and ILI visits as a percentage of total ED visits. Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.
  - » Normal variation in ILI ED and outpatient visits can affect the assessment of daily trends, especially in smaller geographies with low daily visits and by variations in healthcare seeking behavior associated with the day of the week, holidays, and current social distancing measures.
  - » ILI activity levels are traditionally calculated for jurisdictions based on the percent of outpatient visits due to ILI in a jurisdiction compared with the average percent of ILI visits that occur during weeks with little or no influenza virus circulation in that jurisdiction (i.e., non-influenza weeks), adjusted for the sites contributing data for the week. ILI activity values within two standard deviations of the non-influenza week mean are classified as a minimal level of ILI.

- » Given potential changes in healthcare seeking behaviors resulting from community mitigation measures that can significantly affect the denominator of ILI proportions, jurisdictions should analyze within-jurisdiction ILI trends using both the number (count) and proportion of visits to account for this potential bias.

- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the ILI gating indicator is met with respect to these phase transitions.
  - » Transition into Phase One: achieve 14 consecutive days (or two weeks) of downward trajectory or maintaining minimal ILI activity level.
  - » Transition into Phase Two: achieve an additional 14 consecutive days (or two weeks) of improvement (downward trajectory or minimal ILI activity level) without experiencing a rebound (defined below).
  - » Transition into Phase Three: achieve another 14 consecutive days (or two weeks) of improvement (downward trajectory or minimal ILI activity level) without experiencing a rebound (defined below).
- **Identifying Rebound:**
  - » An increase in ILI visits or an increase in ILI activity levels over 5 consecutive days may indicate a potential rebound in COVID-19 activity.
- **Interpretation/Limitations:**
  - » ILI is a nonspecific syndromic measure and can be influenced by the circulation of numerous respiratory pathogens and should be interpreted in the context of virologic and other surveillance data. For example, ILI is expected to fluctuate in the fall and winter due to circulation of seasonal influenza.
  - » The purpose of ILI surveillance is to detect changes in outpatient visits for febrile respiratory illness. The percent of patient visits for ILI can be affected by changes in health care seeking behavior, so jurisdictions should look at numbers (counts) of ILI visits in addition to proportions.
  - » ILI frequency and activity levels within a jurisdiction are influenced by the mix of primary care practice types submitting data. These changes make direct comparisons of ILI from one jurisdiction to another invalid. Calculation of ILI activity levels allows for more appropriate comparison of ILI between jurisdictions.

Downward trajectory of COVID-like illness (CLI) reported within a 14-day period

- **Description/Rationale:** CLI is a syndromic surveillance categorization applied to ED visit symptom and diagnostic code data. This measure is intended to identify areas that are experiencing sustained decreases in ED visits consistent with the presenting symptoms of COVID-19 illness (fever and either cough, shortness of breath, or difficulty breathing) or with a coronavirus diagnostic code that fits CDC interim coding guidelines, and without a diagnostic code for influenza (https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf). CLI can be used to track COVID-19 trends, especially when paired with SARS-CoV-2 and other respiratory pathogen testing data.
- **Data Sources:** Hospitals report ED visits in near real-time to state and/or local health departments and to NSSP. These data are stored within the BioSense Platform where they can be analyzed and exchanged by public health officials. States and jurisdictions may collect syndromic surveillance data on CLI locally that is not submitted to NSSP but could be useful for interpreting the CLI gating indicator.
- **Assessing Decreases:**
  - » To pass the criteria of a 14-day downward trajectory in CLI syndromic cases, a locality must either have experienced 14 days of decreasing cases or exhibit near pre-pandemic levels of CLI. To determine a downward trajectory, the visits data are assessed using a smoothed curve to account for periodic

fluctuations in CLI. To calculate this curve, CDC applies the cubic spline as with ILI and described above. The slope of this curve is used to assess declining incidence. Localities must have 14 days of consecutive downward slope, allowing for 2–3-day grace periods of increasing CLI to allow for irregularities. It is recommended that localities assess both the total counts of CLI visits and CLI visits as a percentage of total ED visits. Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.

  - » Normal variation in CLI ED visits affects the assessment of daily trends, especially in smaller geographies with low daily visits and by variations in healthcare seeking behavior associated with the day of the week, holidays, and current social distancing measures.

- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the CLI gating indicator is met with respect to these phase transitions.
  - » Transition into Phase One: achieve 14 consecutive days of improvement (downward trajectory or near pre-pandemic CLI ED visits).
  - » Transition into Phase Two: achieve an additional 14 consecutive days of improvement (downward trajectory or near pre-pandemic CLI ED visits) without experiencing a rebound (defined below).
  - » Transition into Phase Three: achieve another 14 consecutive days of improvement (downward trajectory or near pre- pandemic CLI ED visits) without experiencing a rebound (defined below).
- **Identifying Rebound:** Two primary methods can be used to help assess for a rebound in CLI ED visits.
  - » Within NSSP, daily statistical anomaly detection methods are automatically applied to time series trends, and anomalous increases are flagged for further epidemiologic investigation. Multiple consecutive days of anomalies may be an indicator of increases in COVID-19 activity and could be used to focus additional testing of patients.
  - » Regression methods (e.g., binomial regression) can be used to classify time series trends in the last 15 days to detect 5-day periods of significant increase in patients being seen with CLI and can also be used to focus additional investigations and/or confirmatory testing.
- **Interpretation/Limitations:**
  - » The purpose of syndromic surveillance is to find timely, more automated, indicators of a change in patterns of illness or health seeking behaviors in a community than is possible with case reporting. Syndromic data can initiate further confirmatory investigation. CLI is a non-specific syndromic measure and could be influenced by the circulation of other respiratory pathogens.
  - » The timeliest element of ED records is the patient chief complaint text describing their symptoms. The CLI syndrome is based in part on the patient's chief complaint at presentation to the ED, which may or may not actually be COVID-19, but also includes visits that were assigned a COVID-19 diagnosis code.
  - » The data quality and completeness of chief complaint text and diagnostic codes can vary by reporting hospital and can affect the assessment of trends over time.
  - » In general, syndromic categorizations emphasize timeliness and sensitivity over specificity. As such, the CLI gating indictor may exhibit changes earlier than other indicators but may also include visits for other illnesses that have similar symptoms as COVID-19 (e.g., infections with other respiratory viruses). Interpretation of CLI data should always be considered in conjunction with other data and the local context. Data that track the presence of other respiratory illnesses (e.g., respiratory syncytial virus and influenza) circulating within the community may help in assessing whether CLI is due to the virus that causes COVID-19 or other viruses.

Downward trajectory of documented (confirmed and probable) cases within a 14-day period

- **Description/Rationale:** On April 5, 2020, the Council of State and Territorial Epidemiologists (CSTE) issued an interim COVID-19 position statement making COVID-19 a nationally notifiable disease and establishing confirmed and probable case definitions (www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf). The case report gating indicator is intended to identify communities experiencing sustained decreases in the number of new cases occurring each day, an indication of decreases in disease transmission.
- **Data Sources:** Case report information for confirmed and probable cases collected by state and local jurisdictions and submitted to CDC; publicly available aggregated case count data (e.g., USAFacts: https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/); US Census population estimates (used as denominator for incidence calculations)
- **Assessing criteria for reduction in number of cases:** To pass this criterion, a locality must either 1) have experienced 14 days of decreasing cases or 2) be in a low-incidence plateau. A locality that has a new outbreak or rebound cannot advance to the next phase unless they see another 14 days of decline.
- **Defining 14 days of decreasing cases:** To assess a downward trajectory, CDC uses a 3-day rolling average and applies a spline curve (described above). A period of 14 days of declining cases occurs when fewer cases are reported at the end of the 14 days compared with the number at the beginning of the period, using the 3-day rolling average fitted with the spline curve to define the number of cases. In addition, a "grace period" of 5 days may be applied during a downward trajectory, during which cases may increase for no more than 5 consecutive days. (If 5 days of consecutive increase occur, then the jurisdiction has met the criteria for rebound and is no longer in a downward trajectory.) Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.
- **Defining a low incidence plateau**
  - » A low-incidence plateau is defined as a very low number of new cases reported (below 10 cases per 100,000 population over 2 weeks) with only minimal change in daily cases.
  - » To qualify for this category, a locality must previously have seen elevated case counts.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the case report gating indicator is met with respect to these phase transitions. Note that the Opening Up America Again guideline specifies that either the case report gating indictor or the percent positive gating indicator should be met.
  - » Transition into Phase One: achieve 14 consecutive days of improvement (downward trajectory or near-zero incidence).
  - » Transition into Phase Two: achieve an additional 14 consecutive days of improvement (downward trajectory or near-zero incidence) without experiencing a rebound (defined below).
  - » Transition into Phase Three: achieve another 14 consecutive days of improvement (downward trajectory or near-zero incidence) without experiencing a rebound (defined below).
- **Defining rebound**
  - » A rebound occurs when the smoothed, 3-day average of case counts exhibits an increase over a 5 consecutive day period, following a downward trajectory of 14 or more days, including any grace period applied.

- **Interpretation/Limitations:**
  - » Case report data are a lagging indicator for assessing SARS-CoV-2 transmission in the community, as new cases are not identified until after the incubation period occurs, the ill person seeks testing or healthcare for their illness, and the information is reported to health officials.
  - » The choice of the dates used (e.g., onset date, report date) is critical in the interpretation of observed trends. If available, onset date is preferred because it improves timeliness of trend interpretation. However, because date of report is more likely to be available than date of illness onset, it is more frequently the date used to calculate trends. Whatever date is used, the assessment must account for the fact that very recent cases will not have been reported. Excluding recent onset dates or report dates (e.g., in the last 3 days or last week if onset dates are used) from assessment of trends should be considered to ensure that incomplete reporting of recent cases does not give the false appearance of downward trajectory.
  - » CDC analyses are typically based on the date of case report and not diagnosis or onset date because it is the most uniformly available date across jurisdictions. Preliminary analyses of national data show that there is typically an 8- to 10-day lag between the date of symptom onset and the date the case is reported to CDC, but this varies by jurisdiction.
  - » A sustained downward trajectory demonstrates improvement in daily case incidence but does not necessarily equate to a low disease burden. Communities should consider local resource capacity (e.g., availability of public health staff to conduct contact tracing) when determining appropriate incidence thresholds for making phase transition decisions.

Downward trajectory of positive tests as a percent of total tests within a 14-day period with stable or increasing test volume

- **Description/Rationale:** Laboratory test percent positive can be used in combination with, or as an alternative to, observing a decline in new case reports. In circumstances where testing is adequate and testing practices are largely stable, percent positive may be a reliable indicator of COVID-19 activity.
- **Data Sources:** Positive and negative SARS-CoV-2 test results reported by laboratories to state health departments. Data from the Census Bureau's Population Estimates Program can be used to estimate state and county population denominators for per-capita test rates.
- **Assessing Decreases:**
  - » Percent positive is calculated as the number of positive tests divided by the total test results, with total test results defined as the sum of positive tests and negative tests, excluding records where the test was not performed because the specimen was not usable or the test was cancelled. The number of tests with indeterminate results has been small, so not including these in the denominator of total test results should not affect interpretation of the trends observed.
  - » A jurisdiction must see a 14-day downward trajectory in percent positive (or near-zero percent positive) with up to 2–3 consecutive days of increasing or stable percent positive allowed as a grace period if data are inconsistent, while total test volume is stable or increasing.
  - » Methods to assess decreases in laboratory test positivity are similar to those used to assess decreases in ILI and CLI.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the percent positive gating indicator is met with respect to these phase transitions. Note that in the Opening Up America Again guideline, the case report gating indictor or the percent positive gating indicator should be met.
  - » Transition into Phase One: achieve 14 or more consecutive days of decline in percent positive (or near-zero percent positive) while total test volume is stable or increasing.

- » Transition into Phase Two: achieve an additional 14 or more consecutive days of decline in percent positive (or near-zero percent positive) while total test volume is stable or increasing.
- » Transition into Phase Three: achieve an additional 14 or more consecutive days of decline in percent positive (or near-zero percent positive) while total test volume is stable or increasing.
- » If a near-zero plateau has been reached, can meet if plateau is maintained over 14 consecutive days (2–3-day grace period)

- **Identifying Rebound:** Multi-day increases in percent positivity with stable or increasing testing volume should be assessed along with case report and CLI data to identify rebounds.
- **Interpretation/Limitations:**
  - » The daily percent positive may fluctuate, particularly in areas with smaller populations. Total test volume may also vary by day of the week, based on the number of tests ordered or regular system maintenance at laboratories.
  - » The percent positive is driven by the number of people who are positive in a community and the number of people who are tested. Declines in percent positive may result from an expansion of testing to more people. Thus, it is important to track percent positive in combination with the number tested, whether measured as the total volume of all test results, or as total test results per capita. Percent positivity should only be used as an indicator of COVID-19 activity when per capita testing levels are stable over the time period being assessed.
  - » The percent positive may also be affected by a changing proportion of tests in people who are less likely to be infected, such as those who are asymptomatic or who have less severe symptoms. Few laboratories have fields indicating whether the person tested was asymptomatic or whether the patient was in an inpatient or outpatient setting at the time of testing. However, communities can stratify by data source to assess changes in the population tested over time, such as tracking the percent positive in hospital data separately from the percent positive in large commercial laboratories.
  - » The residence of the person tested may not be validated as thoroughly in laboratory data as in case data. Patient zip code may be based on insurance billing data, and thus less likely to be complete and correct when the person tested is uninsured or on another family member's plan.
  - » Provider zip code is generally accurate, when available. However, drive-up facilities might use a central zip code that does not reflect where the physical drive-up facility is located.

Joint interpretation of all four disease occurrence gating criteria

The four disease occurrence gating indicators should be interpreted collectively to reach a determination on the trajectory of COVID-19 activity within a jurisdiction, bearing in mind that the measures differ significantly in their lag, specificity, and sensitivity. Lab testing and syndromic data sources generally have less lag than COVID-19 case report data relative to when transmission occurred. SARS-CoV-2 testing and COVID-19 case reports are more specific measures of COVID-19 activity than the CLI syndrome, but all three are likely far more specific than the ILI syndrome. The CLI syndrome likely has superior sensitivity to the other measures, as it is more likely to capture people with COVID-19 that were not tested. While downward trajectory for a period of 14 days is used for each of the disease occurrence gating indicators in the Opening Up America Again guideline, state and local jurisdictions should use judgment based on their knowledge of local disease surveillance practices and infrastructure in determining whether longer time periods (e.g., 21 or 28 days) are needed before moving to different community mitigation phases.

Other Data Sources and Measures

The four disease occurrence gating indicators above provide insight into both the intensity and trajectory of the COVID-19 pandemic within jurisdictions. In addition, other epidemiologic data sources are available to local, state, and federal health officials and can be used to confirm trends observed in the disease occurrence gating indicators.

- **COVID-19 hospital admissions:** Depending on the overall COVID-19 incidence rate, the size of the jurisdiction, and the regional hospital referral patterns, hospitalizations for laboratory-confirmed COVID-19 can be an important measure to assess trajectory. Testing is likely more complete and less variable in hospitalized populations, providing more assurance that observed trends are not driven by testing practices. In addition to helping verify increases or decreases in the disease occurrence gating indicators, monitoring COVID-19 hospital admissions (and discharges) can help assess the burden on local healthcare capacity.
- **COVID-19 deaths:** Depending on the overall COVID-19 incidence rate and the size of the jurisdiction, deaths due to COVID-19 may occur in high enough numbers to reliably assess the trajectory of the outbreak in the jurisdiction. Although they represent a small proportion of all COVID-19 illnesses and significantly lag the core disease occurrence gating indicators, vital records are a universally collected data source and should be available for review in all jurisdictions. Further, observing declines in newly reported COVID-19 deaths almost certainly indicates that demands on the healthcare system are waning. Care should be taken to understand the extent and variability in SARS-CoV-2 testing for deceased individuals in the jurisdiction when using death as a source of data to understand the overall trajectory of COVID-19 illnesses in the jurisdiction. COVID-19 death data reported to CDC's National Center for Health Statistics are published weekly by state (https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm).
- **Measures of trajectory:** The effective reproductive number (the average number of secondary cases from an infectious case in an a particular population at a specific point in time) and doubling time (the time required for the number of cases to double) are epidemiologic measures that can be used to characterize the speed with which illnesses are spreading in an outbreak. Although these measures can be imprecise, especially when calculated within smaller populations, they provide alternative ways to analyze and characterize the trajectory of COVID-19 activity.

Implied in the Core State Preparedness Responsibilities in the *Opening Up America Again* guideline is the need for jurisdictions to have confidence in the epidemiologic data being used to make assessments about the magnitude and trajectory of COVID-19 illnesses. In order for most of the gating indicators to be reliably assessed, 1) rapid testing should be occurring as indicated for all clinical, public health, and infection prevention needs and 2) all new symptomatic COVID-19 cases in the jurisdiction should be able to be rapidly identified through active surveillance of laboratories and healthcare facilities. In the absence of widespread testing and robust active surveillance, jurisdictions should be cautious when adjusting mitigation strategies based on the disease occurrence gating indicators. Several measures, listed below, can be helpful in providing an indirect assessment of the completeness of case ascertainment in a jurisdiction.

- COVID-19 case-fatality ratio: Case-fatality is defined as the proportion of COVID-19 cases result in death. Although estimates of the percentage of symptomatic COVID-19 illnesses that result in death has varied widely, the overall percentage is likely lower than 1–2%. Although many factors contribute to disease severity, including the underlying health status of the population, jurisdictions that have very high COVID-19 case-fatality ratios (above 5–10%) may be under-ascertaining COVID-19 illnesses. This could indicate that case reporting is an unreliable measure of true COVID-19 activity. In this situation it may be useful to examine measures for CLI syndrome or COVID-19 hospital admissions as measures of disease activity.

- High percent positive: Although changes in percent positive is an indicator in the Opening Up America Again guideline, very high proportions of SARS-CoV-2 positivity (e.g., >25%) may be an indicator that testing levels are not adequate and that COVID-19 illnesses are being under-ascertained in the jurisdiction, as it suggests that only a limited number of people with a high likelihood of being infected with SARS-CoV-2 are able to be tested. In this situation it also may useful to look at the CLI syndrome or at COVID-19 hospital admissions as measures of disease activity, since they are likely less susceptible to the influence of testing availability.
- Per capita testing: It is difficult to determine a widely applicable benchmark for a per capita level of SARS-CoV-2 testing that is sufficient to have confidence in the adequacy of COVID-19 case-ascertainment. However, jurisdictions can consider evaluating their per capita testing to assist in judging whether testing levels are adequate for effective COVID-19 surveillance.
- Proportion of cases with an unknown source: Improvements in case ascertainment and contact tracing should lead to a lower proportion of new cases with an unknown exposure to SARS-CoV-2. Jurisdictions can consider tracking the proportion of new COVID-19 cases without a documented exposure source (e.g., travel to a high-incidence region or country, exposure to someone with a confirmed case of COVID-19, attending and event or going to a setting with suspected SARS-CoV-2 transmission). Although difficult to achieve, jurisdictions that have fewer than 50% of new cases with an unknown exposure source likely have likely achieved high levels of case ascertainment, interviewing, and contact tracing.

Hospital Indicators

Capacity to treat all patients without crisis care

- **Description/Rationale:** Capacity indicators, including percentage of inpatients and ICU beds occupied and PPE supplies, help identify areas where additional healthcare capacity needs may exist now or in the future.
- **Data sources:** Data within HHS Protect, including from CDC's National Healthcare Safety Network (NHSN) (a healthcare infection associated tracking system), provide information on inpatient and ICU bed occupancy, staffing shortages, and PPE supplies.
- **Assessing indicator:** All three measures of treating patients without crisis care should be met before a jurisdiction moves to the next community mitigation phase.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the hospital indicators are met with respect to these phase transitions.
  - » Transition into Phase One: Inpatient and ICU beds <80% full for 7 consecutive days AND no staff shortages for 7 consecutive days AND PPE supplies adequate and available for >4 days.
  - » Transition into Phase Two: Inpatient and ICU beds <75% full for 7 consecutive days AND no staff shortages for 7 consecutive days AND PPE supplies adequate and available for >4 days.
  - » Transition into Phase Three: Inpatient and ICU beds <70% full for 7 consecutive days AND no staff shortages for 7 consecutive days AND PPE supplies adequate and available for >15 days.
- **Interpretation/Limitations:**
  - » Hospitals within the same jurisdiction may be at different stages with regard to these measures. Public health officials should assess the status of the jurisdiction's hospital capacity overall and consider whether resources (e.g., clinical staff, PPE) could be re-allocated to address differential needs.

Robust testing program

- **Description/Rationale:**
  - » The percentage of positive diagnostic tests for SARS-CoV-2 can be used as an indirect measure of agreement between testing demand and test availability. A target frequency of negative tests (e.g., 80% negative) must be established as an indicator of "adequate" availability of tests. This threshold can then be used to monitor for regional shortages and target distribution of testing resources to areas with greatest need.
  - » Timeliness of results is another measure of laboratory testing capacity, and prompt results are essential for effective contact tracing.
- **Data sources:** Positive and negative SARS-CoV-2 test results reported by laboratories to state health departments. Median time between test order and results can be calculated from the reported laboratory data.
- **Assessing indicator:** Both criteria for a robust testing program should be met before a jurisdiction moves to the next community mitigation phase. The metric for percentage positive tests can be assessed as the percentage of positive of viral tests among all tests with a result for 14 consecutive days. An alternative would be to have daily percent positive below the phase transition threshold for 14 consecutive days.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the indicators for a robust testing program are met with respect to these phase transitions.
  - » Transition into Phase One: Percentage positive tests ≤20% for 14 days AND median time from test order to result <4 days.
  - » Transition into Phase Two: Percentage positive tests ≤15% for 14 days AND median time from test order to result <3 days.
  - » Transition into Phase Three: Percentage positive tests ≤10% for 14 days AND median time from test order to result <2 days.
- **Interpretation/Limitations:**
  - » This indicator refers to tests for current infection (e.g., nucleic acid (PCR) or antigen tests). Serology (i.e., antibody) testing metrics should not be used for this indicator.
  - » Lags in test reporting may lead to incomplete data for calculating percent positive tests for the most recent few days. Jurisdictions should calculate percent positive for the most recent 14 days with near-complete testing data.

Additional Considerations

Overall Incidence Level

The disease occurrence gating indicators all pertain to assessing the trajectory of COVID-19 activity, but do not specify that COVID-19 incidence should reach an absolute level to move through the mitigation phases. Jurisdictions should be cautious in pivoting from a general community mitigation approach back toward an identification and containment approach until incidence is low enough and resources adequate to 1) attempt an initial interview for nearly all new COVID-19 cases within one day of health department notification, 2) to rapidly isolate all newly identified COVID-19 cases, and 3) to initiate appropriate follow up (isolation, self-monitoring, and rapid testing of symptomatic contacts) for nearly all identified contacts of newly identified cases. Incidence should also be low enough that health departments can respond to large outbreaks (e.g., nursing home outbreaks)

that require substantial resources to investigate and control. Declines in incidence should also be enough for healthcare capacity to not only meet current demands, but to be able to comfortably surge in the event of an increase in cases (e.g., availability of acute care beds, critical care beds, ventilators, and adequate PPE).

Special Populations and Settings

Infections in high-risk settings and populations can disproportionately impact localized transmission and the ability of public health capacity to keep pace with follow up needs such as contract tracing and screening. Efforts should be taken to monitor infections in some specific populations and settings, including but not limited to healthcare personnel, patients in healthcare facilities (e.g., nursing homes, dialysis centers, long term care facilities), and residents of congregate living settings (e.g., prisons, youth homes, shelters). In addition, identification of illnesses at work places (e.g., meat and poultry processing facilities) or events with the potential for "explosive spread" (e.g., mass gatherings) may warrant adjustment of community mitigation measures in the absence of community-wide changes in the disease occurrence gating indicators.

Neighboring Jurisdictions

When making decisions about adjusting community mitigation measures, state and local jurisdictions also should coordinate with officials in neighboring areas to assess the burden and trajectory of COVID-19 illnesses in the surrounding region. Neighboring or nearby jurisdictions with significantly higher incidence or with increasing COVID-19 activity could reintroduce SARS-CoV-2 to a jurisdiction, jeopardizing improvements within the jurisdiction.

Measures of Mobility and Social Distancing

If available, it may be important to understand the knowledge, attitudes and behaviors of the community as it relates to the public health guidance provided within the local jurisdiction. Survey data and data on mobility can be useful in understanding if community members are aware of and following established social distancing and isolation guidelines and informing changes in the mitigation strategies used. Several publicly available data sources currently exist that generate measures of social distancing and mobility, frequently based on mobile phone location services or social media data.

Summary

The disease occurrence gating indicators in the *Opening Up America Again* guideline provide states and communities insight into the trajectory of the COVID-19 pandemic in their jurisdiction. The disease occurrence gating indicators should be evaluated collectively, considering their relative strengths and weaknesses, in the context of other epidemiologic data available for the jurisdiction. The hospital indicators are designed to help decision makers understand the health system's ability to handle a potential surge in cases. These indicators are part of the broad assessment jurisdictions should undertake when deciding when and how to adjust community mitigation strategies for COVID-19.

Table 5. Gating Criteria Summary

Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in ED and/or outpatient visits for influenza-like illness (ILI) Decreases in ED and/or outpatient visits for COVID-like illness (CLI)	Downward trajectory of ILI/CLI (or minimal ILI activity or near pre-pandemic level of CLI ED visits) reported over a 14-day period • Uses a 3-day average in a cubic smoothing spline • 14 consecutive days of decline required but can use a 2–3 day grace period if data are inconsistent • Look at both total visits for ILI/CLI and percentage of visits for ILI/CLI • 14th day must be lower than 1st day • If near pre-pandemic level of CLI ED visits has been reached, can meet if pre-pandemic level is maintained over 14 consecutive days (2–3 day grace period)	Downward trajectory of ILI/CLI (or minimal ILI activity or near pre-pandemic level of CLI ED visits) reported for at least 14 days after entering Phase 1 without experiencing a rebound • Same criteria but for a second 14-day period • Rebound is determined if the trajectory increases in a 5-day period	Downward trajectory of ILI/CLI (or minimal ILI activity or near pre-pandemic level of CLI ED visits) reported for at least an additional 14 days after entering Phase 2 without experiencing a rebound • Same criteria but for a second 14-day period • Rebound is determine if the trajectory increases in a 5-day period

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Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in newly identified COVID-19 cases	Downward trajectory (or near-zero incidence) of documented cases over a 14-day period • Uses a 3-day average in a cubic smoothing spline • 14 consecutive days of decline required but can use up to a 5-day grace period if data are inconsistent • 14th day must be lower than 1st day • To be near-zero incidence, must have fewer than 10 cases per 100k population over 14 days) and must have previously had elevated cases	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days after entering Phase 1 • Same criteria as Phase 1 for another 14 days • Rebound is defined as having 5 consecutive days of increase	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days after entering Phase 2 • Same criteria as Phase 2 for another 14 days • Rebound is defined as having 5 consecutive days of increase
Decreases in newly identified COVID-19 cases	Downward trajectory (or near-zero incidence) of documented cases over a 14-day period • Uses a 3-day average in a cubic smoothing spline • 14 consecutive days of decline required but can use up to a 5-day grace period if data are inconsistent • 14th day must be lower than 1st day • To be near-zero incidence, must have fewer than 10 cases per 100k population over 14 days) and must have previously had elevated cases	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for 14 days after entering Phase 1 (flat or increasing volume of tests) • Same criteria as Phase 1 for another 14 days • Rebound is defined as having multi-day increases in percent positivity with stable or increasing testing volume. • Look at positive results and cases when assessing for rebound	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for at least 14 days after entering Phase 2 (flat or increasing volume of tests) • Same criteria as Phase 1 for another 14 days • Rebound is defined as having multi-day increases in percent positivity with stable or increasing testing volume. • Look at positive results and cases when assessing for rebound

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Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in percentage of SARS-CoV-2 tests positive	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests over a 14-day period (flat or increasing volume of tests) • Divide total positive results by total positive + negative • Remove incomplete and inconclusive results • 14 consecutive days of downward trend with up to 2–3 consecutive days of a grace period due to data inconsistency • 14th day must be lower than 1st day • If a near-zero plateau has been reached, can meet if plateau is maintained over 14 consecutive days (2–3 day grace period) • Test volume must remain the same or be increasing to use this criterion • Should include all test results from all labs	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for 14 days after entering Phase 1 (flat or increasing volume of tests) • Same criteria as Phase 1 for another 14 days • Rebound is defined as having multi-day increases in percent positivity with stable or increasing testing volume. • Look at positive results and cases when assessing for rebound	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for at least 14 days after entering Phase 2 (flat or increasing volume of tests) • Same criteria as Phase 1 for another 14 days • Rebound is defined as having multi-day increases in percent positivity with stable or increasing testing volume. • Look at positive results and cases when assessing for rebound
Treat all patients without crisis care	Jurisdiction inpatient & ICU beds <80% full Staff shortage in last week = no PPE supplies adequate for >4 days	Jurisdiction inpatient & ICU beds <75% full Staff shortage in last week = no PPE supplies adequate for >4 days	Jurisdiction inpatient & ICU beds <70% full Staff shortage in last week = no PPE supplies adequate for >15 days
Robust testing program	Test availability such that % positive tests <20% for 14 days Median time from test order to result <4 days	Test availability such that % positive tests <15% for 14 days Median time from test order to result <3 days	Test availability such that % positive tests <10% for 14 days Median time from test order to result <2 days

Appendix F: Setting Specific Guidance

CDC offers this interim guidance to assist establishments as they open. CDC will update this guidance as it learns more about COVID-19 and best practices to prevent its spread.

This guidance is meant to supplement the decision tools CDC released on May 14, 2020. It lists specific practices that employers may find helpful at particular stages of the COVID-19 outbreak. This guidance sets forth a menu of safety measures, from which establishments may choose those that make sense for them in the context of their operations and local community, as well as state and local regulations and directives.

INTERIM GUIDANCE FOR CHILD CARE PROGRAMS

The gradual scale up of activities towards pre-COVID-19 operating practices at childcare programs is crucial to helping parents and guardians return to work. Many states have closed schools for the academic year and, with summer quickly approaching, an increasing number of working parents may need to rely on these programs. CDC's Interim Guidance for Administrators of US K-12 Schools and Child Care Programs and supplemental Guidance for Child Care Programs that Remain Open provide recommendations for operating childcare programs in low, moderate, and significant mitigation communities. In communities that are deemed significant mitigation areas by state and local authorities, childcare programs should be closed. However, childcare programs can choose to remain open to serve children of essential workers, such as healthcare workers. All decisions about following these recommendations should be made locally, in collaboration with local health officials who can help determine levels of COVID-19 community transmission and the capacities of the local public health system and healthcare systems. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of operations. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Scaling Up Operations

- **In all Steps:**
  - » Establish and maintain communication with local and State authorities to determine current mitigation levels in your community.
  - » Protect and support staff, children, and their family members who are at higher risk for severe illness.
  - » Provide staff from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to childcare programs in lower transmission (later Step) areas and vice versa.
  - » Follow CDC's supplemental Guidance for Child Care Programs that Remain Open.
  - » Encourage any other community groups or organizations that use the childcare facilities also follow this guidance.
- **Step 1:** Restrict to children of essential workers.
- **Step 2:** Expand to all children with enhanced social distancing measures.
- **Step 3:** Remain open for all children with social distancing measures.

Safety Actions

Promote healthy hygiene practices (Steps 1–3)

- Teach and reinforce washing hands and covering coughs and sneezes among children and staff.
- Teach and reinforce use of cloth face coverings among all staff. Face coverings are most essential at times when social distancing is not possible. Staff should be frequently reminded not to touch the face covering and to wash their hands frequently. Information should be provided to all staff on proper use, removal, and washing of cloth face coverings.
- Have adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol (for staff and older children who can safely use hand sanitizer), paper towels, and tissues.
- Post signs on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean, sanitize, and disinfect frequently touched surfaces (for example, playground equipment, door handles, sink handles, drinking fountains) multiple times per day and shared objects between use.
- Avoid use of items (for example, soft or plush toys) that are not easily cleaned, sanitized, or disinfected.
- Ensure safe and correct application of disinfectants and keep products away from children.
- Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if doing so poses a safety or health risk (for example, allowing pollens in or exacerbating asthma symptoms) to children using the facility.
- Take steps to ensure that all water systems and features (for example, drinking fountains or decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing

- **Steps 1 and 2**
  - » Ensure that classes include the same group of children each day and that the same childcare providers remain with the same group each day, if possible.
  - » Restrict mixing between groups.
  - » Cancel all field trips, inter-group events, and extracurricular activities (Step 1).
  - » Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Step 2; Note: restricting attendance from those in Step 1 areas).
  - » Restrict nonessential visitors, volunteers, and activities involving other groups at the same time.
  - » Space out seating and bedding (head-to-toe positioning) to 6 feet apart if possible.
  - » Close communal use spaces, such as game rooms or dining halls, if possible; if this is not possible, stagger use and disinfect in between uses.
  - » If a cafeteria or group dining room is typically used, serve meals in classrooms instead. Put each child's meal on a plate, to limit the use of shared serving utensils and ensure the safety of children with food allergies.
  - » Stagger arrival and drop-off times or put in place other protocols to limit direct contact with parents as much as possible.

- **Step 3**
  - » Consider keeping classes together to include the same group of children each day, and consider keeping the same childcare providers with the same group each day.
  - » Allow minimal mixing between groups. Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Step 1 or 2 areas).
  - » Continue to space out seating and bedding (head-to-toe positioning) to 6 feet apart, if possible.
  - » Consider keeping communal use spaces closed, such as game rooms, playgrounds, or dining halls, if possible; if this is not possible, stagger use and disinfect in between uses.
  - » Consider continuing to plate each child's meal, to limit the use of shared serving utensils and ensure the safety of children with food allergies.
  - » Consider limiting nonessential visitors, volunteers, and activities involving other groups. Restrict attendance of those from higher transmission areas (Step 1 or 2 areas).
  - » Consider staggering arrival and drop-off times or putting in place other protocols to limit close contact with parents or caregivers as much as possible.
- **Limit sharing** (Steps 1–3)
  - » Keep each child's belongings separated and in individually labeled storage containers, cubbies, or areas and taken home each day and cleaned, if possible.
  - » Ensure adequate supplies to minimize sharing of high-touch materials to the extent possible (art supplies, equipment etc. assigned to a single child) or limit use of supplies and equipment by one group of children at a time and clean and disinfect between use.
  - » If food is offered at any event, have pre-packaged boxes or bags for each attendee instead of a buffet or family-style meal.
  - » Avoid sharing of foods and utensils.
  - » Avoid sharing electronic devices, toys, books, other games, and learning aids.
  - » Prevent risk of transmitting COVID-19 by avoiding immediate contact (such as shaking or holding hands, hugging, or kissing).
- Train all staff (Steps 1–3)
  - » Train all staff in the above safety actions. Consider conducting the training virtually, or, if in-person, ensure social distancing is maintained.

Monitoring and Preparing

Check for signs and symptoms (Steps 1–3)

- Screen children upon arrival, if possible. Establish routine, daily health checks on arrival, such as temperature screening of both staff and children. Options for daily health check screenings for children are provided in CDC's supplemental Guidance for Child Care Programs that Remain Open and in CDC's General Business FAQs for screening staff.
- Implement health checks (e.g. temperature checks and symptom screening) screenings safely and respectfully, and with measures in place to ensure confidentiality as well as in accordance with any applicable privacy laws or regulations. Confidentiality should be maintained.

- Employers and childcare directors may use examples of screening methods in CDC's supplemental Guidance for Child Care Programs that Remain Open as a guide.
- Encourage staff to stay home if they are sick and encourage parents to keep sick children home.

Plan for when a staff member, child, or visitor becomes sick (Steps 1–3)

- Identify an area to separate anyone who exhibits COVID-like symptoms during hours of operation, and ensure that children are not left without adult supervision.
- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility, as appropriate.
- Notify local health officials, staff, and families immediately of any possible case of COVID-19 while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by any sick person and do not use them until they have been cleaned. Wait 24 hours before you clean or disinfect to reduce risk to individuals cleaning. If it is not possible to wait 24 hours, wait as long as possible. Ensure safe and correct application of disinfectants, and keep disinfectant products away from children
- Advise sick staff members or children not to return until they have met CDC criteria to discontinue home isolation.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.

Maintain healthy operations (Steps 1–3)

- Implement flexible sick leave policies and practices, if feasible.
- Monitor absenteeism to identify any trends in employee or child absences due to illness. This might indicate spread of COVID-19 or other illness. Have a roster of trained back-up staff in order to maintain sufficient staffing levels.
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- Create a communication system for staff and families for self-reporting of symptoms and notification of exposures and closures.
- Support coping and resilience among employees and children.

Steps 1–3

- It is very important to check State and local health department notices daily about spread of COVID-19 in the area and adjust operations accordingly.
- Where a community is deemed a significant mitigation community, childcare programs should close, except for those caring for the children of essential workers, such as the children of health care workers.
- In the event a person diagnosed with COVID-19 is determined to have been in the building and poses a risk to the community, programs may consider closing for a few days for cleaning and disinfection.

INTERIM GUIDANCE FOR SCHOOLS AND DAY CAMPS

As communities consider a gradual scale up of activities towards pre-COVID-19 operating practices in centers for learning, such as K–12 schools and summer day camps, CDC offers the following recommendations to keep communities safe while resuming peer-to-peer learning and providing crucial support for parents and guardians returning to work. These recommendations depend on community monitoring to prevent COVID-19 from spreading. Communities with low levels of COVID-19 spread and those with confidence that the incidence of infection is genuinely low (e.g., communities that remain in low transmission or that have entered Step 2 or 3) may put in place the practices described below as part of a gradual scale up of operations. All decisions about following these recommendations should be made in collaboration with local health officials and other state and local authorities who can help assess the current level of mitigation needed based on levels of COVID-19 community transmission and the capacities of the local public health and healthcare systems, among other relevant factors. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of operations. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Scaling Up Operations

- **In all Steps:**
  - » Establish and maintain communication with local and state authorities to determine current mitigation levels in your community.
  - » Protect and support staff and students who are at higher risk for severe illness, such as providing options for telework and virtual learning.
  - » Follow CDC's Guidance for Schools and Childcare Programs.
  - » Provide teachers and staff from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to schools and camps in lower transmission (later Step) areas and vice versa.
  - » Encourage any other external community organizations that use the facilities also follow this guidance.
- **Step 1:** Schools that are currently closed, remain closed. E-learning or distance learning opportunities should be provided for all students. Support provision of student services such as school meal programs, as feasible. Camps should be restricted to children of essential workers and for children who live in the local geographic area only.
- **Step 2:** Remain open with enhanced social distancing measures and for children who live in the local geographic area only.
- **Step 3:** Remain open with distancing measures. Restrict attendance to those from limited transmission areas (other Step 3 areas) only.

Safety Actions

Promote healthy hygiene practices (Steps 1–3)

- Teach and reinforce washing hands and covering coughs and sneezes among children and staff.
- Teach and reinforce use of face coverings among all staff. Face coverings may be challenging for students (especially younger students) to wear in all-day settings such as school. Face coverings should be worn by staff and encouraged in students (particularly older students) if feasible and are most essential in times when

physical distancing is difficult. Information should be provided to staff and students on proper use, removal, and washing of cloth face coverings. Face coverings are not recommended for babies or children under the age of 2, or for anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the covering without assistance. Cloth face coverings are meant to protect other people in case the wearer is unknowingly infected (many people carry COVID-19 but do not have symptoms). Cloth face coverings are not surgical masks, respirators, or personal protective equipment.

- Have adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol (for staff and older children who can safely use hand sanitizer), paper towels, tissues, and no-touch trash cans.
- Post signs on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean and disinfect frequently touched surfaces within the school and on school buses at least daily (for example, playground equipment, door handles, sink handles, drinking fountains) as well as shared objects (for example, toys, games, art supplies) between uses.
- To clean and disinfect school buses, see guidance for bus transit operators.
- Ensure safe and correct application of disinfectants and keep products away from children.
- Ensure ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if they pose a safety or health risk (e.g., allowing pollens in or exacerbating asthma symptoms) risk to children using the facility.
- Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing

- **Step 1 and 2**
  - » Ensure that student and staff groupings are as static as possible by having the same group of children stay with the same staff (all day for young children, and as much as possible for older children).
  - » Restrict mixing between groups.
  - » Cancel all field trips, inter-group events, and extracurricular activities (Step 1).
  - » Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Step 2; Note: restricting attendance from those in Step 1 areas).
  - » Restrict nonessential visitors, volunteers, and activities involving other groups at the same time.
  - » Space seating/desks to at least 6 feet apart.
  - » Turn desks to face in the same direction (rather than facing each other), or have students sit on only one side of tables, spaced apart.
  - » Close communal use spaces such as dining halls and playgrounds if possible; otherwise stagger use and disinfect in between use.
  - » If a cafeteria or group dining room is typically used, serve meals in classrooms instead. Serve individually plated meals and hold activities in separate classrooms and ensure the safety of children with food allergies.

- » Stagger arrival and drop-off times or locations, or put in place other protocols to limit close contact with parents or caregivers as much as possible.
- » Create social distance between children on school buses (for example, seating children one child per seat, every other row) where possible.

- **Step 3**
  - » Consider keeping classes together to include the same group of children each day, and consider keeping the same child care providers with the same group each day.
  - » Allow minimal mixing between groups. Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Step 1 or 2 areas).
  - » Continue to space out seating and bedding (head-to-toe positioning) to 6 feet apart, if possible.
  - » Consider keeping communal use spaces closed, such as game rooms or dining halls, if possible; if this is not possible, stagger use and disinfect in between uses.
  - » Consider continuing to plate each child's meal, to limit the use of shared serving utensils and ensure the safety of children with food allergies.
  - » Consider limiting nonessential visitors, volunteers, and activities involving other groups. Restrict attendance of those from higher transmission areas (Step 1 or 2 areas).
  - » Consider staggering arrival and drop-off times or locations, or put in place other protocols to limit close contact with parents or caregivers as much as possible.

Limit sharing (Steps 1–3)

- Keep each child's belongings separated from others' and in individually labeled containers, cubbies, or areas and taken home each day and cleaned, if possible.
- Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single student/camper) or limit use of supplies and equipment by one group of children at a time and clean and disinfect between use.
- If food is offered at any event, have pre-packaged boxes or bags for each attendee instead of a buffet or family-style meal. Avoid sharing of foods and utensils.
- Avoid sharing electronic devices, toys, books, and other games or learning aids.

Train all staff (Steps 1–3)

- Train all teachers and staff in the above safety actions. Consider conducting the training virtually, or, if in-person, ensure that social distancing is maintained.

Check for signs and symptoms (Steps 1–3)

- If feasible, conduct daily health checks (e.g. temperature screening and/or symptoms checking) of staff and students safely, respectfully, as well as in accordance with any applicable privacy laws or regulations. Confidentiality should be maintained.
- School and camp administrators may use examples of screening methods in CDC's supplemental Guidance for Child Care Programs that Remain Open as a guide for screening children and CDC's General Business FAQs for screening staff.
- Encourage staff to stay home if they are sick and encourage parents to keep sick children home.

Plan for when a staff member, child, or visitor becomes sick (Steps 1–3)

- Work with school administrators, nurses, and other healthcare providers to identify an isolation room or area to separate anyone who exhibits COVID-like symptoms. School nurses and other healthcare providers should use Standard and Transmission-Based Precautions when caring for sick people. See: What Healthcare Personnel Should Know About Caring for Patients with Confirmed or Possible COVID-19 Infection.
- Establish procedures for safely transporting anyone sick home or to a healthcare facility.
- Notify local health officials, staff, and families immediately of a possible case while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by a sick person and do not use before cleaning and disinfection. Wait 24 hours before you clean and disinfect. If it is not possible to wait 24 hours is, wait as long as possible. Ensure safe and correct application of disinfectants and keep disinfectant products away from children.
- Advise sick staff members and children not to return until they have met CDC criteria to discontinue home isolation.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.

Maintain healthy operations (Steps 1–3)

- Implement flexible sick leave policies and practices, if feasible.
- Monitor staff absenteeism and have a roster of trained back-up staff.
- Monitor health clinic traffic. School nurses and other healthcare providers play an important role in monitoring health clinic traffic and the types of illnesses and symptoms among students.
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- Create a communication system for staff and families for self-reporting of symptoms and notification of exposures and closures.
- Support coping and resilience among employees and children.

Closing

Steps 1–3

- Check state and local health department notices daily about transmission in the area and adjust operations accordingly.
- In the event a person diagnosed with COVID-19 is determined to have been in the building and poses a risk to the community, programs may consider closing for a short time (1–2 days) for cleaning and disinfection.

INTERIM GUIDANCE FOR EMPLOYERS WITH WORKERS AT HIGH RISK

As workplaces consider a gradual scale up of activities towards pre-COVID-19 operating practices, it is particularly important to keep in mind that some workers are at higher risk for severe illness from COVID-19. These workers include individuals over age 65 and those with underlying medical conditions. Such underlying conditions include, but are not limited to, chronic lung disease, moderate to severe asthma, hypertension, severe heart conditions, weakened immunity, severe obesity, diabetes, liver disease, and chronic kidney disease that requires dialysis. Workers at higher risk for severe illness should be encouraged to self-identify, and employers should avoid making unnecessary medical inquiries. Employers should take particular care to reduce workers' risk of exposure to COVID-19, while making sure to be compliant with relevant Americans with Disabilities Act (ADA) and Age Discrimination in Employment Act (ADEA) regulations. First and foremost, this means following CDC and the Occupational Safety and Health Administration (OSHA) guidance for reducing workplace exposure for all employees. All decisions about following these recommendations should be made in collaboration with local health officials and other state and local authorities who can help assess the current level of mitigation needed based on levels of COVID-19 community transmission and the capacities of the local public health and healthcare systems. In addition, the guidance offered below applies to workplaces generally; specific industries may require more stringent safety precautions. Finally, there may be essential workplaces in which the recommended mitigation strategies are not feasible. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of operations. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Scaling Up Operations

- **In all Steps:**
  - » Establish and maintain communication with local and state authorities to determine current mitigation levels in your community.
  - » Protect employees at higher risk for severe illness by supporting and encouraging options to telework.
  - » Consider offering workers at higher risk duties that minimize their contact with customers and other employees (e.g., restocking shelves rather than working as a cashier), if agreed to by the worker.
  - » Encourage any other entities sharing the same work space also follow this guidance.
  - » Provide employees from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to workplaces in lower transmission (later Step) areas and vice versa.
- **Step 1:** Scale up only if business can ensure strict social distancing, proper cleaning and disinfecting requirements, and protection of their workers and customers; workers at higher risk for severe illness are recommended to shelter in place.
- **Step 2:** Scale up only if business can ensure moderate social distancing, proper cleaning and disinfecting requirements, and protection of their workers and customers; workers at higher risk for severe illness are recommended to shelter in place.
- **Step 3:** Scale up only if business can ensure limited social distancing, proper cleaning and disinfecting requirements, and protection of their workers and customers.

Safety Action

Promote healthy hygiene practices (Steps 1–3)

- Enforce hand washing, covering coughs and sneezes, and using cloth face coverings when around others where feasible;
- however, certain industries may require face shields.
- Ensure that adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol, tissues, paper towels, and no-touch trash cans.
- Post signs on how to stop the spread of COVID-19 properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean and disinfect frequently touched surfaces at least daily and shared objects between use.
- Avoid use or sharing of items that are not easily cleaned, sanitized, or disinfected.
- Ensure safe and correct application of disinfectants.
- Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if doing so poses a safety risk to individuals and employees using the workspace.
- Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing (Steps 1–3)

- Limit service to drive-throughs, curbside take out, or delivery options, if possible (Step 1).
- Consider installing physical barriers, such as sneeze guards and partitions, and changing workspace layouts to ensure all individuals remain at least 6 feet apart.
- Close communal spaces, such as break rooms, if possible (Step 1) or stagger use and clean and disinfect in between uses (Steps 2 & 3).
- Encourage telework for as many employees as possible.
- Consider rotating or staggering shifts to limit the number of employees in the workplace at the same time.
- Replace in-person meetings with video- or tele-conference calls whenever possible.
- Cancel all group events, gatherings, or meetings of more than 10 people (Step 1), of more than 50 people (Step 2), and any events where social distancing of at least 6 feet cannot be maintained between participants (all Steps).
- Restrict (Step 1) or consider limiting (Step 2) any nonessential visitors, volunteers, and activities involving external groups or organizations.
- Limit any sharing of foods, tools, equipment, or supplies.

Limit travel and modify commuting practices (Steps 1–3)

- Cancel all non-essential travel (Step 1) and consider resuming non-essential travel in accordance with state and local regulations and guidance (Steps 2 & 3).

- Ask employees who use public transportation to consider using teleworking to promote social distancing.
- Train all managers and staff in the above safety actions. Consider conducting the training virtually, or if in-person, ensure that social distancing is maintained.

Monitoring and Preparing

Checking for signs and symptoms (Steps 1–3)

- Consider conducting routine, daily health checks (e.g., temperature and symptom screening) of all employees.
- If implementing health checks, conduct them safely and respectfully, and in accordance with any applicable privacy laws and regulations. Confidentiality should be respected. Employers may use examples of screening methods in CDC's General Business FAQs as a guide.
- Encourage employees who are sick to stay at home.

Plan for when an employee becomes sick (Steps 1–3)

- Employees with symptoms (fever, cough, or shortness of breath) at work should immediately be separated and sent home.
- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility.
- Notify local health officials, staff, and customers (if possible) immediately of a possible case while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by the sick person until after cleaning and disinfection Wait 24 hours to clean and disinfect. If it is not possible to wait 24 hours, wait as long as possible before cleaning and disinfecting. Ensure safe and correct application of disinfectants and keep disinfectant products away from children.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.
- Sick employees should not return to work until they have met CDC's criteria to discontinue home isolation.

Maintain healthy operations (Steps 1–3)

- Implement flexible sick leave and other flexible policies and practices, such as telework, if feasible.
- Monitor absenteeism of employees and create a roster of trained back-up staff.
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- Create and test communication systems for employees for self-reporting and notification of exposures and closures.
- Support coping and resilience among employees.

Closing

Steps 1–3

- Check state and local health department notices daily about transmission in the area and adjust operations accordingly.
- Be prepared to consider closing for a few days if there is a case of COVID-19 in the workplace or for longer if cases increase in the local area.

INTERIM GUIDANCE FOR RESTAURANTS AND BARS

This guidance provides considerations for businesses in the food service industry (e.g., restaurants and bars) on ways to maintain healthy business operations and a safe and healthy work environment for employees, while reducing the risk of COVID-19 spread for both employees and customers. Employers should follow applicable Occupational Safety and Health Administration (OSHA) and CDC guidance for businesses to plan and respond to COVID-19. All decisions about implementing these recommendations should be made in collaboration with local health officials and other state and local authorities who can help assess the current level of mitigation needed based on levels of COVID-19 community transmission and the capacities of the local public health and healthcare systems. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of activities towards pre-COVID-19 operating practices. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Scaling Up Operations

- **In all Steps:**
  - » Establish and maintain communication with local and state authorities to determine current mitigation levels in your community.
  - » Consider assigning workers at high risk for severe illness duties that minimize their contact with customers and other employees (e.g., managing inventory rather than working as a cashier, managing administrative needs through telework).
  - » Provide employees from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to workplaces in lower transmission (later Step) areas and vice versa.
- **Step 1:** Bars remain closed and restaurant service should remain limited to drive-through, curbside take out, or delivery with strict social distancing.
- **Step 2:** Bars may open with limited capacity; restaurants may open dining rooms with limited seating capacity that allows for social distancing.
- **Step 3:** Bars may open with increased standing room occupancy that allows for social distancing; restaurants may operate while maintaining social distancing.

Safety Actions

Promote healthy hygiene practices (Steps 1–3)

- Enforce hand washing, covering coughs and sneezes, and use of a cloth face coverings by employees when near other employees and customers.
- Ensure adequate supplies to support healthy hygiene practices for both employees and customers including soap, hand sanitizer with at least 60 percent alcohol (on every table, if supplies allow), paper towels, and tissues.
- Post signs on how to stop the spread of COVID-19 properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean and disinfect frequently touched surfaces (for example, door handles, workstations, cash registers) at least daily and shared objects (for example, payment terminals, tables, countertops/bars, receipt trays, condiment holders) between use. Use products that meet EPA's criteria for use against SARS-CoV-2 and that

are appropriate for the surface. Prior to wiping the surface, allow the disinfectant to sit for the necessary contact time recommended by the manufacturer. Train staff on proper cleaning procedures to ensure safe and correct application of disinfectants.

- Make available individual disinfectant wipes in bathrooms.
- Wash, rinse, and sanitize food contact surfaces, food preparation surfaces, and beverage equipment after use.
- Avoid using or sharing items such as menus, condiments, and any other food. Instead, use disposable or digital menus, single serving condiments, and no-touch trash cans and doors.
- Use touchless payment options as much as possible, when available. Ask customers and employees to exchange cash or card payments by placing on a receipt tray or on the counter rather than by hand. Clean and disinfect any pens, counters, or hard surfaces between use or customer.
- Use disposable food service items (utensils, dishes). If disposable items are not feasible, ensure that all non-disposable food service items are handled with gloves and washed with dish soap and hot water or in a dishwasher. Employees should wash their hands after removing their gloves or after directly handling used food service items
- Use gloves when removing garbage bags or handling and disposing of trash and wash hands afterwards
- Avoid using food and beverage containers or utensils brought in by customers.
- Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if doing so poses a safety risk to employees, children, or customers.
- Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing

Step 1

- Limit service to drive-through, delivery, or curb-side pick-up options only.
- Provide physical guides, such as tape on floors or sidewalks to ensure that customers remain at least 6 feet apart in lines or ask customers to wait in their cars or away from the establishment while waiting to pick up food. Post signs to inform customers of food pickup protocols.
- Consider installing physical barriers, such as sneeze guards and partitions at cash registers, or other food pickup areas where maintaining physical distance of 6 feet is difficult.
- Restrict the number of employees in shared spaces, including kitchens, break rooms, and offices to maintain at least a six-foot distance between people.
- Rotate or stagger shifts to limit the number of employees in the workplace at the same time.

Step 2

- Provide drive-through, delivery, or curb-side pick-up options and prioritize outdoor seating as much as possible.
- Reduce occupancy and limit the size of parties dining in together to sizes that ensure that all customer parties remain at least 6 feet apart (e.g., all tables and bar stools 6 feet apart, marking tables/stools that are not for use) in order to protect staff and other guests.

- Provide physical guides, such as tape on floors or sidewalks and signage on walls to ensure that customers remain at least 6 feet apart in lines or waiting for seating.
- Ask customers to wait in their cars or away from the establishment while waiting to be seated. If possible, use phone app technology to alert patrons when their table is ready to avoid touching and use of "buzzers."
- Consider options for dine-in customers to order ahead of time to limit the amount of time spent in the establishment.
- Avoid offering any self-serve food or drink options, such as buffets, salad bars, and drink stations.
- Install physical barriers, such as sneeze guards and partitions at cash registers, bars, host stands, and other areas where maintaining physical distance of 6 feet is difficult.
- Limit the number of employees in shared spaces, including kitchens, break rooms, and offices to maintain at least a six-foot distance between people.

Step 3

- Provide drive-through, delivery, or curbside pick-up options and prioritize outdoor seating as much as possible.
- Consider reducing occupancy and limiting the size of parties dining in together to sizes that ensure that all customer parties remain at least 6 feet apart (e.g., all tables and bar stools 6 feet apart, marking tables/stools that are not for use) in order to protect staff and other guests.
- Provide physical guides, such as tape on floors or sidewalks and signage on walls, to ensure that customers remain at least 6 feet apart in lines or waiting for seating.
- If possible, use phone app technology to alert patrons when their table is ready to avoid touching and use of "buzzers."
- Consider options for dine-in customers to order ahead of time to limit the amount of time spent in the establishment.
- Avoid offering any self-serve food or drink options, such as buffets, salad bars, and drink stations.
- Install physical barriers, such as sneeze guards and partitions at cash registers, bars, host stands, and other areas where maintaining physical distance of 6 feet is difficult.

Train all staff (Steps 1–3)

- Train all employees in the above safety actions while maintaining social distancing and use of face coverings during training.

Monitoring and Preparing

Checking for signs and symptoms (Steps 1–3)

- Consider conducting daily health checks (e.g., temperature and symptom screening) of employees.
- If implementing health checks, conduct them safely and respectfully, and in accordance with any applicable privacy laws and regulations. Confidentiality should be respected. Employers may use examples of screening methods in CDC's General Business FAQs as a guide.
- Encourage staff who are sick to stay at home.

Plan for when an employee becomes sick (Steps 1–3)

- Employees with symptoms of COVID-19 (fever, cough, or shortness of breath) at work should immediately be sent to their home.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.
- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility.
- Notify local health officials, staff, and customers (if possible) immediately of any possible case of COVID-19 while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by a sick person and do not sure them until after cleaning and disinfection. Wait 24 hours before cleaning and disinfecting. If it is not possible to wait 24 hours, wait as long as possible. Ensure safe and correct application of disinfectants and keep disinfectant products away from children.
- Advise sick staff members not to return until they have met CDC's criteria to discontinue home isolation.

Maintain healthy operations (Steps 1–3)

- Implement flexible sick leave and other flexible policies and practices, such as telework, if feasible.
- Monitor absenteeism of employees and create a roster of trained back-up staff.
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- Create and test communication systems for employees for self-reporting and notification of exposures and closures.
- Support coping and resilience among employees.

Closing

Steps 1–3

- Check state and local health department notices about transmission in the area daily and adjust operations accordingly.
- Be prepared to consider closing for a few days if there is a case of COVID-19 in the establishment and for longer if cases increase in the local area.

INTERIM GUIDANCE FOR MASS TRANSIT ADMINISTRATORS

Mass transit is critical for many Americans to commute to and from work and to access essential goods and services. This guidance provides considerations for mass transit administrators to maintain healthy business operations and a safe and healthy work environment for employees, while reducing the risk of COVID-19 spread for both employees and passengers. Administrators should follow applicable guidance from the CDC and Occupational Safety and Health Administration (OSHA) for reducing workplace exposure. All decisions about following these recommendations should be made in collaboration with local health officials and other state and local authorities who can help assess the current level of mitigation needed based on levels of

COVID-19 community transmission and the capacities of the local public health and healthcare systems. CDC is releasing this interim guidance, laid out in a series of three steps, to inform a gradual scale up of activities towards pre-COVID-19 operating practices. The scope and nature of community mitigation suggested decreases from Step 1 to Step 3. Some amount of community mitigation is necessary across all steps until a vaccine or therapeutic drug becomes widely available.

Resuming Full Service

- **In all Steps:**
  - » Adjust routes between areas experiencing different levels of transmission (between areas in different Steps), to the extent possible.
  - » Provide employees from higher transmission areas (earlier Step areas) telework and other options as feasible to eliminate travel to workplaces in lower transmission (later Step) areas and vice versa.
  - » Establish and maintain communication with state and local health officials to determine current mitigation levels in the communities served. Decisions about how and when to resume full service should be based on these levels.
  - » Follow CDC's guidance on what bus transit operators, rail transit operators, transit maintenance workers, and transit station workers need to know about COVID-19.
  - » Consider assigning workers at high risk of severe illness duties that minimize their contact with passengers and other employees
  - » Conduct worksite hazard assessments to identify COVID-19 prevention strategies, such as appropriate use of cloth face coverings or personal protective equipment (PPE), and follow the prevention strategies.
- **Step 1:** Restrict ridership to essential critical infrastructure workers in areas needing significant mitigation and maintain strict social distancing as much as possible.
- **Step 2:** Maintain social distancing between transit riders and employees as much as possible.
- **Step 3:** Encourage social distancing as much as possible.

Safety Actions

Promote healthy hygiene practices (Steps 1–3)

- Enforce everyday preventive actions such as hand washing, covering coughs and sneezes, and use of a cloth face covering by employees when around others, as safety permits. Provide employees with appropriate personal protective equipment as necessary and as available. Communicate with the public about the importance of hygiene, covering coughs and sneezes, and using cloth face coverings while using mass transportations, including posting signs in transit stations and vehicles on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face covering.

- Ensure adequate supplies to support healthy hygiene behaviors for transit operators, employees, and passengers in stations, including soap, hand sanitizer with at least 60 percent alcohol, paper towels, tissues, and no-touch trash cans.
- Post signs on how to stop the spread of COVID-19 properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Steps 1–3)

- Clean and disinfect frequently touched surfaces (for example, kiosks, digital interfaces such as touchscreens and fingerprint scanners, ticket machines, turnstiles, handrails, restroom surfaces, elevator buttons) at least daily or between use as feasible.
- Clean and disinfect the operator area between operator shifts.
- Use touchless payment and no-touch trash cans and doors as much as possible, when available. Ask customers and employees to exchange cash or credit cards by placing in a receipt tray or on the counter rather than by hand and wipe any pens, counters, or hard surfaces between each use or customer.
- Avoid using or sharing items that are not easily cleaned, sanitized, or disinfected, such as disposable transit maps.
- Ensure safe and correct application of disinfectants.
- Use gloves when removing garbage bags or handling and disposing of trash and wash hands afterwards.
- Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible such as by opening windows and doors. Do not open windows and doors if they pose a safety risk to passengers or employees, or other vulnerable individuals.
- Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Promote social distancing

Step 1 and Step 2

- Institute measures to physically separate or create distance of at least 6 feet between all occupants to the extent possible. This may include:
  - » Asking bus passengers to enter and exit the bus through rear doors, while allowing exceptions for persons with disabilities.
  - » Closing every other row of seats.
  - » Reducing maximum occupancy of buses and individual subway and train cars and increasing service on crowded routes as appropriate.
- Provide physical guides to ensure that customers remain at least 6 feet apart while on vehicles and at transit stations and stops. For example, floor decals, colored tape, or signs to indicate where passengers should not sit or stand can be used to guide passengers.
- Install physical barriers, such as sneeze guards and partitions at staffed kiosks and on transit vehicles to the extent practicable.
- Close communal spaces, such as break rooms, if possible; otherwise, stagger use and clean and disinfect in between uses.

Step 3

- Consider or continue instituting measures to physically separate or create distance between occupants.
- Provide physical guides to help customers maintain physical distance while on vehicles and at transit stations and stops. For example, floor decals, colored tape, or signs to indicate where passengers should not sit or stand can be used to guide passengers.
- Install or maintain physical barriers, such as sneeze guards and partitions at staffed kiosks and on transit vehicles to the extent practicable.

Train employees (Steps 1–3)

- Train all employees in the above safety actions while maintaining social distancing during training.

Monitoring and Preparing

Checking for signs and symptoms (Steps 1–3)

- Consider conducting daily health checks (e.g., temperature screening and/or symptom checking) of all employees.
- If implementing health checks, conduct them safely and respectfully, and in accordance with any applicable privacy laws and regulations. Confidentiality should be respected. Employers may use examples of screening methods in CDC's General Business FAQs as a guide.
- Encourage staff who are sick to stay at home.

Plan for when an employee becomes sick (Steps 1–3)

- Employees with symptoms of COVID-19 (fever, cough, or shortness of breath) at work should immediately be sent home.
- Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.
- Establish procedures for safely transporting anyone sick to their home or to a healthcare facility.
- Notify local health officials, staff, and customers (if possible) immediately of any possible case of COVID-19 while maintaining confidentiality consistent with the Americans with Disabilities Act (ADA) and other applicable federal and state privacy laws.
- Close off areas used by a sick person and do not use until after cleaning and disinfection. Wait 24 hours before cleaning and disinfecting. If 24 hours is not feasible, wait as long as possible. Ensure safe and correct application of disinfectants and keep disinfectant products away from children. Affected vehicles can be used immediately after cleaning and disinfection.
- Advise sick staff members not to return until they have met CDC's criteria to discontinue home isolation.
- Implement safety practices for critical infrastructure workers who may have had exposure to a person with suspected or confirmed COVID-19.

Maintain healthy operations (Steps 1–3)

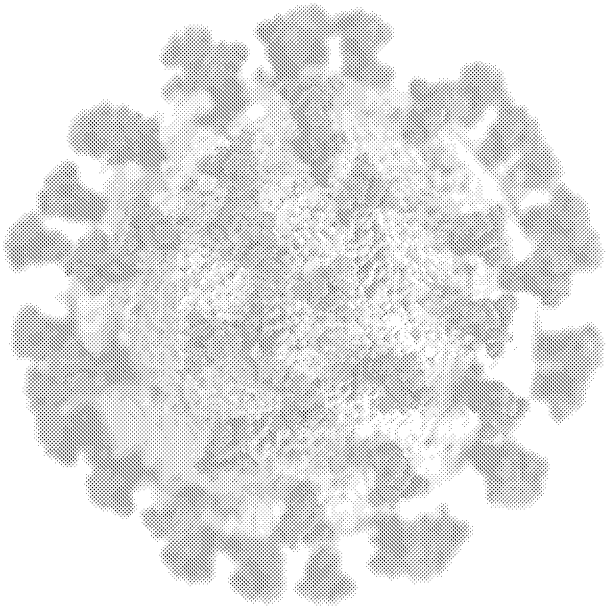
- Implement flexible sick leave and other flexible policies and practices, if feasible.
- Monitor absenteeism of employees and create a roster of trained back-up staff.

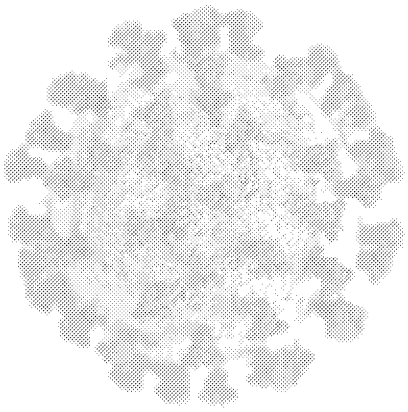
- Designate a staff person to be responsible for responding to COVID-19 concerns. Employees and customers should know who this person is and how to contact them.
- Create and test communication systems for employees and customers for self-reporting of symptoms and notification of exposures and closures.
- Support coping and resilience among employees.

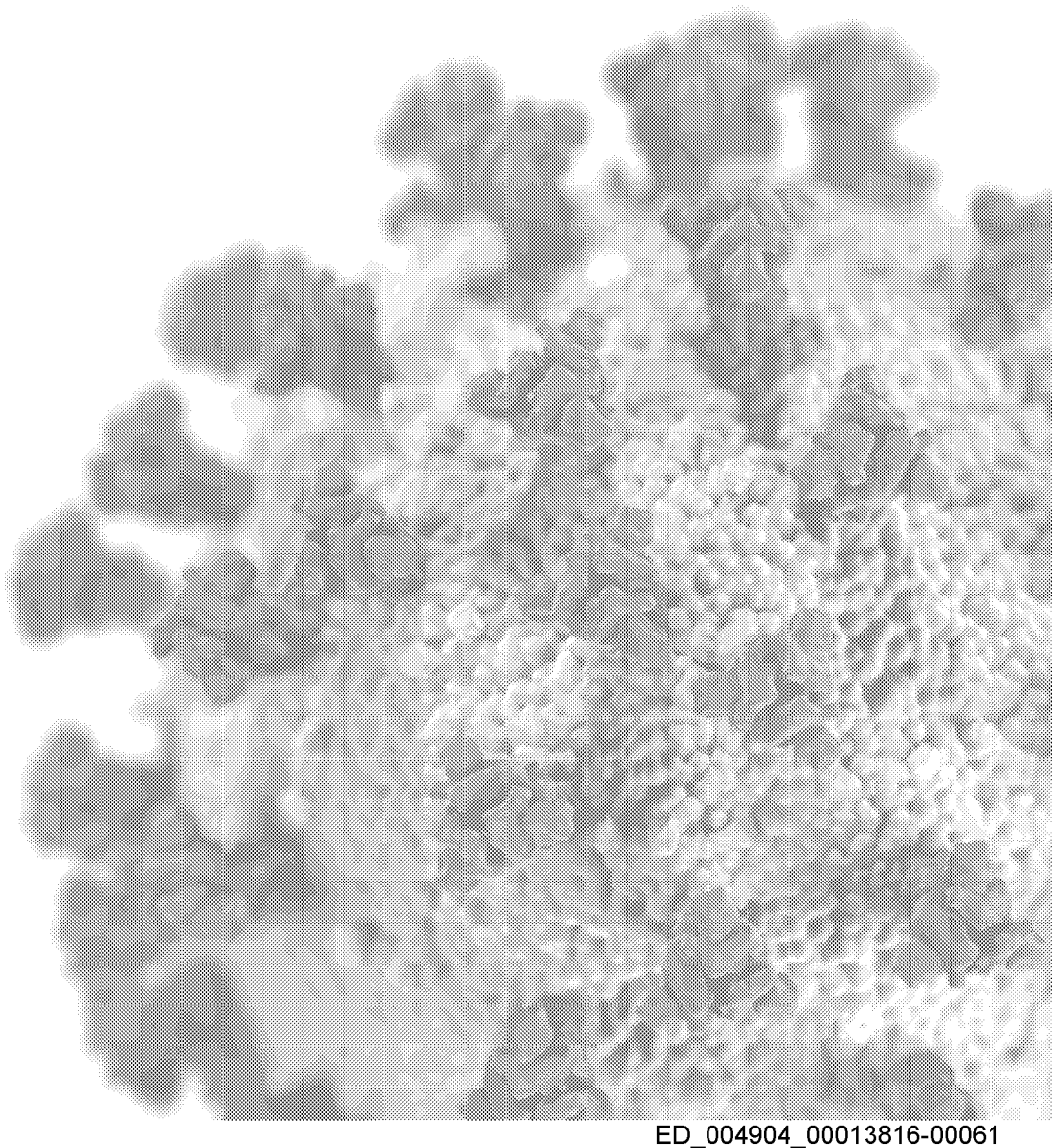
Adjusting Service

Steps 1–3

- Coordinate with state and local health department officials about transmission in the area as frequently as possible and adjust operations accordingly.
- Be prepared to consider adjusting services as appropriate if the community mitigation level increases in the local area.
- Continue communication with staff and the public about decision-making.







cdc.gov/coronavirus

U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

CS317670-A June 16, 2020 2:25 PM

Message

From: Bell, Matthew [Bell.Matthew@epa.gov]
Sent: 6/29/2020 1:37:05 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]
Subject: OECA FW: Opening status
Attachments: FW: Office Operations and Return to Workplace Notification; FW: Office Operations and Return to Workplace Notification; FW: Office Operations and Return to Workplace Notification; FW: Office Operations and Return to Workplace Notification

Regarding the OECA office reopening, **Ex. 5 Deliberative Process (DP)**

Ex. 5 Deliberative Process (DP)

Matthew Bell
Senior Advisor|Office of Mission Support
U.S. Environmental Protection Agency
(202)564-3282

From: Barnet, Henry <Barnet.Henry@epa.gov>
Sent: Friday, June 26, 2020 9:28 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Cc: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>; Starfield, Lawrence <Starfield.Lawrence@epa.gov>; Taylor, Jessica <taylor.jessica@epa.gov>; Owens, Ted <Owens.Ted@epa.gov>; Mazakas, Pam <Mazakas.Pam@epa.gov>
Subject: RE: Opening status

Ok – we'll transition those offices to Phase 1 and monitor any entry into those facilities.

Thanks,
Henry

Henry E. Barnet, Director
Office of Criminal Enforcement, Forensics & Training
U.S. Environmental Protection Agency
1200 Pennsylvania Avenue, N.W.
WJC South Room 1211
Washington, D.C. 20004
202.564.2480

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 25, 2020 9:32 PM
To: Barnet, Henry <Barnet.Henry@epa.gov>
Cc: Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Bell, Matthew <Bell.Matthew@epa.gov>; Starfield, Lawrence <Starfield.Lawrence@epa.gov>; Taylor, Jessica <taylor.jessica@epa.gov>; Owens, Ted <Owens.Ted@epa.gov>; Mazakas, Pam <Mazakas.Pam@epa.gov>
Subject: Re: Opening status

Ex. 5 Deliberative Process (DP)

On Jun 25, 2020, at 8:51 PM, Barnet, Henry <Barnet.Henry@epa.gov> wrote:

Donna,

Ex. 5 Deliberative Process (DP)

Thanks,
Henry

Henry E. Barnet, Director
Office of Criminal Enforcement, Forensics & Training
U.S. Environmental Protection Agency
1200 Pennsylvania Avenue, N.W.
WJC South Room 1211
Washington, D.C. 20004
202.564.2480

From: Starfield, Lawrence <Starfield.Lawrence@epa.gov>
Sent: Thursday, June 25, 2020 7:08 PM
To: Barnet, Henry <Barnet.Henry@epa.gov>; Mazakas, Pam <Mazakas.Pam@epa.gov>; Taylor, Jessica <taylor.jessica@epa.gov>; Owens, Ted <Owens.Ted@epa.gov>
Cc: Badalamente, Mark <Badalamente.Mark@epa.gov>; Milton, Laura <Milton.Laura@epa.gov>
Subject: Opening status

Henry et al.,

Here are today's decisions by the Administrator on the re-opening status of OECA offices. Please implement.

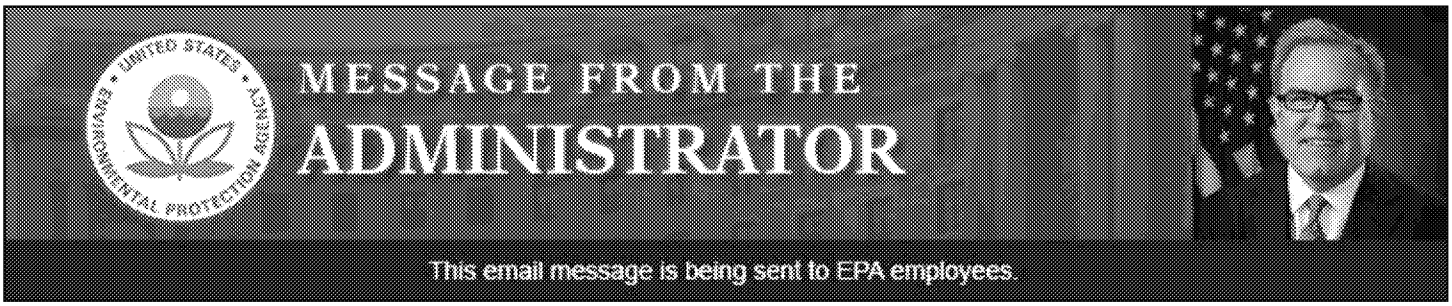
Thanks.

Larry

<AAW decisions on OECA 6 25 20.xlsx>

Message

From: Message from the Administrator [messagefromtheadministrator@epa.gov]
To: Message from the Administrator [messagefromtheadministrator@epa.gov]
Subject: Protective Measures in the Workplace



Colleagues,

For 50 years, the EPA has been committed to protecting human health and the environment. Now as we all adjust our lives during the current COVID-19 situation, and gradually prepare locations to return to the office, I want to assure you that we are taking every measure to ensure that we maintain a healthy work environment. As we move forward with reopening various locations, we are carefully monitoring the impacts of COVID-19, just like you, and are working to protect your health and wellbeing.

After consultation with HQ and regional leadership and based on our assessment of the gating criteria, a review of the local conditions, and the reopening status of the states and cities, Region 2 and Ann Arbor, MI, along with several smaller facilities will begin the reopening process. Effective on close of business Monday, June 22, these offices will be closing for all employees, except for those engaged in mission-critical work, in order to enter the seven-day closure. Per the CDC, the virus that causes COVID-19 has not been shown to survive on surfaces for longer than seven days. Therefore, in accordance with the cleaning guidance developed by EPA and CDC, we close our office buildings for seven days prior to possibly moving into Phase 1 of reopening a location. This closure will render the virus inactive.

For all of our locations, we are taking additional precautionary measures-such as the seven-day closure-to ensure a safe and healthy return to EPA facilities. Our facility mangers across the Agency meet on a regular basis to address any issues or concerns. For example, we are ensuring the safety of our buildings' water systems and devices after a prolonged closure by following CDC Guidance for Building Water Systems as well as our own EPA guidance on Maintaining or Restoring Water Quality in Buildings with Low or No Use. We are also working with the General Services Administration to ensure that our buildings are properly maintained by following CDC's guidance on optimum engineering controls for the building ventilation systems.

Many federal facilities remained operational during the shutdown, and our building engineers and support staff have continued operations of the building systems. I would like to thank our facility managers across EPA whose diligent work helps ensure a safe return to EPA facilities. Specific actions being taken include:

- Cleaning air handlers;
- Changing HVAC filters;
- Continuing to run the HVAC system;
- Running and/or flushing water systems;
- Maintaining pest management inspections and services; and

- Cleaning frequently touched surfaces including elevator buttons, doorknobs/handles, handrails, light switches, countertops, restrooms, and water fountains.

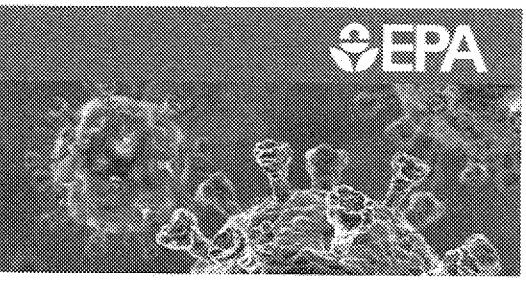
Once we reopen, we will remain committed to keeping our facilities properly cleaned and sanitized. Safety recommendations can and will likely change in accordance with the CDC recommendations as well as local guidance.

Finally, as a reminder, we are minimizing risk to employees during our gradual reopening by continuing to encourage telework during Phase 1 and Phase 2. Employees with dependent care issues will continue to have access to enhanced work hours and workdays.

We are all in this together and adapting together. I encourage you all to stay safe. I am thinking about you and look forward to when we are back together again.

Andrew Wheeler
Administrator

EPA Phase 3 Guidance



Phase 3 Guidance

This document provides additional guidance to National Program Managers (NPMs) and Regions for updating plans to return to the office in a safe and thoughtful manner consistent with Centers for Disease Control and Prevention (CDC) recommendations for social distancing and with continued flexibilities for vulnerable populations and employees with dependent care responsibilities. Plans need to be updated by each organization prior to entering Phase 3.

As we continue to plan for Phase 3, it is important to keep the gating criteria for Phase 3 in mind. We will continue to monitor and adjust where necessary.

OFFICE RETURN/SOCIAL DISTANCING

EPA will follow the CDC recommendation for Social Distancing. For a period of time while transitioning we will utilize regular and situational telework (see Telework section below) to provide social distancing for those employees working in a cubicle or in an enclosed shared office. Staff working in enclosed private offices will return to their previous regular telework schedule. Social distancing plans will be reviewed every eight weeks or when CDC requirements change.

Each National Program and Region will develop a social distancing plan for employees working in cubicles, shared offices, and common spaces in each of their locations. The Office of Mission Support will provide a plan for common spaces in the National Capital Region. Every employee, including those working in private offices, will be placed in a daily cohort group. This will allow each location to develop social distancing plans around employee schedules.

Each NPM/Region will evaluate its floor plans and designate cohorts of employees to follow a daily schedule that provides for social distancing.

NPMS/Regions should review and include social distancing plans for common spaces such as conference rooms.

While it is critical to have a structured schedule for our workforce to ensure their safety and well-being while working in an office environment, for personnel working in the research, program and regional laboratories, supervisors should work closely with those staff to tailor their individual work schedules based on the nature of their work. For example, conducting

experiments, analyses and research may have many different timeframes, as well as requirements for access to equipment and other resources that may not be conducive to structured, intermittent schedules.

FLEXIBILITIES

Dependent Care

For those with dependent care issues, expanded situational telework will remain available, along with the extended workday hours of 5:00 am to 11:30 pm and voluntary Saturday hours. Employees should complete the dependent care form and provide it to their supervisor. Flexibilities should be appropriate to the specific dependent care situation. Employees and supervisors will review these flexibilities every eight weeks.

Vulnerable Populations

Employees in this category or who have a member of the vulnerable population in their household should work with their supervisors to identify appropriate workplace flexibilities needed, such as expanded situational telework or use of videoconferencing while in the office. These employees should return to their normal work hours while teleworking and may utilize the extended workplace hours if on a flexible schedule during any office days as described below. Employees may self-certify as to being in the vulnerable population or having someone in their household in the vulnerable population. Employees and supervisors will review these flexibilities every eight weeks.

Identification of Flexibilities

Each NPM/Region must request employees self-identify if they are in any of the following groups:

- Employees with dependent care issues.
- Employees in a vulnerable population or with a household member who is part of a vulnerable population and seeking flexibility.

Supervisors will then work with each employee on the specific flexibility needed.

ENTERING PHASE 3

Phase 3 will begin with a two-week transition period. During this transition time, employees who will be coming into the office regularly in Phase 3 are required to return to the workplace at least one day each week based on their cohort schedule. This requirement allows for an early opportunity to test social distancing plans, gather feedback and modify facility plans (e.g., elevator capacity), and allows employees to evaluate mass transit options (if applicable).

Once the two-week transition period has concluded, employees are expected to return to the office in accordance with their locations' social distancing plan. Exceptions would include employees leveraging dependent care or vulnerable population flexibilities, regular telework days, situational telework days, compressed workdays or when leave is used.

Telework

All employees in cubicles or shared offices will be eligible for a minimum of five days of telework per pay period during the first eight weeks of Phase 3 in conjunction with the social distancing plan. These five days will be a combination of regular telework and situational telework as available under the Agency Telework Policy or as outlined in each collective bargaining agreement, whichever is greater. Employees may work with their supervisors to adjust their telework schedule as needed while maintaining the office's social distancing plan. This flexibility will be reviewed prior to the expiration of the eight weeks.

Work Schedules

For those on a flexible work schedule, extended workday hours of 5:30 am to 9:00 pm will be available for the days an employee is in the office. This would create a greater range of arrival and departure times to assist with elevator capacity concerns and commuting outside the normal rush hour. For those exercising dependent care flexibilities, extended workday hours of 5:00 am to 11:30 pm and voluntary Saturday hours will remain in place (though hours worked in the office would be limited to 5:30 am to 9:00 pm weekdays).

Mass Transit

If mass transit operation is deemed to impact returning to the office, workforce flexibilities such as expanded use of telework or continuing in-office work schedule flexibilities will be considered to mitigate the impact. This will be a facility-specific decision with concurrence by the Acting Deputy Administrator.

Service and Support Staff

Service and support staff who are in regular physical proximity to their customers will receive additional social distancing support. Personnel requiring assistance are required to wear face coverings when interacting in person and to maintain the six feet social distancing protocol when practical. Social distancing signage will be posted by service and support staff workstations. Plans developed by the NPMs/Regions will include the specific support to be provided.

Face Coverings

EPA will follow local requirements for the use of cloth face coverings. Generally, employees are expected to have their own masks for transit to and from the building and within the building space consistent with local requirements. Each EPA location will have a small number of face

coverings available should the employee arrive at work without one or should they not have a mask and require support services where social distancing is not feasible.

Message

From: Shaw, Betsy [Shaw.Betsy@epa.gov]
Sent: 6/18/2020 9:11:13 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Newton, Cheryl [Newton.Cheryl@epa.gov]
Subject: RE: Ann Arbor is a go
Attachments: Ann Arbor is a go

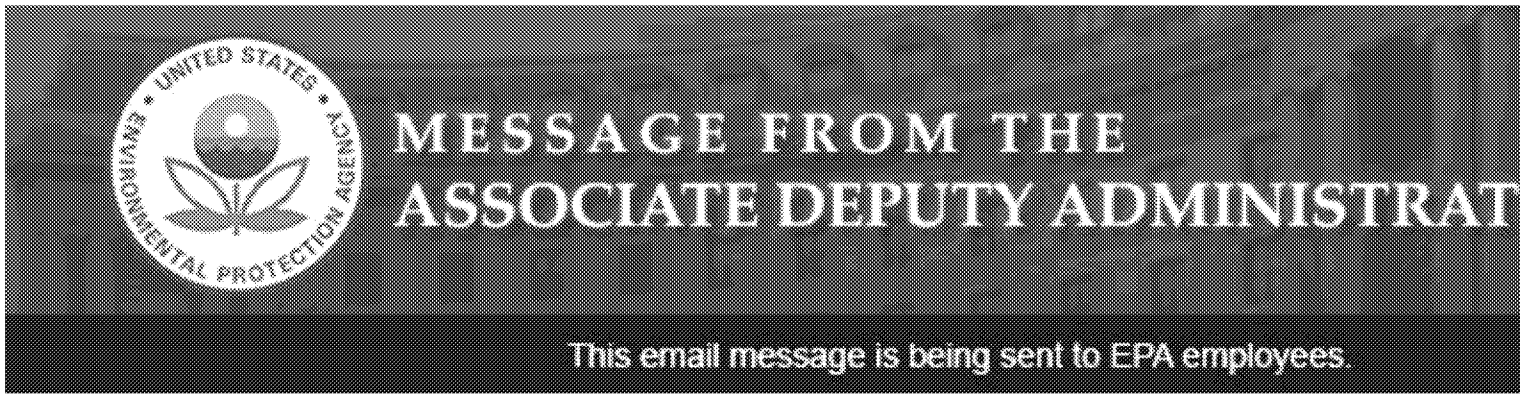
Great! Thanks Donna. We'll send notice post haste. Okay to include the yellow sentence in the description of the state of MI order? (Was not included in Robin's spreadsheet).

Ex. 5 Deliberative Process (DP)

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 18, 2020 5:09 PM
To: Shaw, Betsy <Shaw.Betsy@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>
Subject: Ann Arbor is a go

Message

From: Message from the Associate Deputy Administrator [messagefromtheassociatedeputyadministrator@epa.gov]
To: Message from the Associate Deputy Administrator [messagefromtheassociatedeputyadministrator@epa.gov]
Subject: EPA Phase 3 Guidance COVID-19 Update



Dear Colleagues,

We committed early on during the pandemic to put together plans for our eventual return to the office that protected e upon data and guidance from public health professionals. Along with placing a premium on employee safety these pla would be supplemented to consider feedback from the regions and national program managers. We want to provide a the Workplace Plan, specifically our supplemental agency guidance for Phase 3.

As the Administrator stated in his May 21st message, we are implementing a rolling reopening and moving through th collected on the EPA dashboard and considering what state and local governments are doing. Following these criteria and move through the phasing process considering conditions unique to the 125 EPA facilities across the country.

As the nation opens more businesses and resumes public activities, we've developed additional specific EPA Phase 3 guidance already in place. Consistent with the Administrator's June 11 Mass Mailer additional telework is available for

1. Are in a CDC at-risk category for COVID-19 or;
2. Live with someone in that at-risk category or;
3. Have dependent care responsibilities that are unresolved.

Additionally, employees with dependent care responsibilities may continue to work expanded hours and days. These f up to two months after entering Phase 3 and can be extended as appropriate. As discussed previously if mass transit that would also be a basis to grant additional telework.

Further, the Administrator has instructed the regions and NPMs that the first two weeks of Phase 3 are transitional. Ma employees on a rolling return during those first two weeks as part of the transition back into the workplace. Employees office and teleworking during this time. Also, managers are authorized during the first two months of Phase 3 to grant pay period if necessary, for appropriate social distancing.

We believe these additions to the Phase 3 plan will help provide for a safe return to the workplace for our employees. information provides reason for more updates, we will act.

Thank you for your work for the Agency.

Doug Benevento
Associate Deputy Administrator

Background

The Environmental Protection Agency's (EPA) Plan to return to the workplace provides for a data driven approach alongside an evaluation of site-specific conditions and state and local health department requirements. We will use the three-phase approach as outlined in the Guidelines for Opening Up America Again. The plan provides for a "rolling reopening," so each facility will progress though the phases based on review of the Centers for Disease Control and Prevention (CDC) information for the location as well as local conditions.

This Plan is based on the Office of Management and Budget (OMB) memorandum dated April 20, 2020, which establishes criteria for federal agencies to conduct assessments before reoccupying facilities. These criteria provide guidance to all federal agencies as they make reopening decisions in the three-phase approach. The gating criteria are:

1. Influenza-like illnesses and COVID-like cases of illness must trend downward for 14 calendar days.
2. Documented COVID-19 cases and prevalence of positive tests must trend downward for 14 calendar days.
3. Local hospitals must have the capacity to treat all patients without crisis care, and jurisdictions must have a robust healthcare worker testing program and plan in place.

EPA will also rely on the EPA/CDC Cleaning Guidance and close a facility prior to lifting the current telework posture and entering Phase 1. This is because the virus is rendered inactive without a host after seven days.

This plan will be reviewed as CDC information and advisories are updated.

Process

When making decisions on reopening facilities we consider the criteria provided by OMB/OPM and use data that is provided to us by the Department of Health and Human Services. The Administrator after consulting with senior leadership makes the decisions on reoccupying facilities and moving through phases.

1) What facilities could be ready to enter the seven-day closure period.
2) If facilities at the end of the seven-day closure are ready to enter Phase 1.
3) If a facility should move into the next phase.

Progression though the phases will be based on a continued review of the CDC information and decisions and guidance of state and local authorities, and any other relevant information.

If during any phase, a location encounters a significant increase in the gating criteria trend or hospitals return to crisis care, that location will be reviewed by senior leadership for return to the previous phase.

Employee Telework and Work Schedule Status

PHASE 1

In Phase 1, facilities will be open, and employees have the option to return to the workplace. Telework will be encouraged whenever possible and feasible with business operations. COOP and maximum telework are lifted, but employees will continue to be provided the flexibility of unscheduled telework. All employees may also continue to use expanded work hours and the expanded work week if on a Maxiflex or Flexitour schedule. Employees entering the workplace will be asked to self-screen as outlined in the attached document. Employees choosing the option to telework in Phase 1 should notify their immediate supervisor.

Employees in a category CDC determines as higher-risk, those who are pregnant, or those living with a higher-risk or pregnant individual, should continue to telework during Phase 1.

Employees should also continue to telework through Phase 1 that have dependent care responsibilities because COVID-19 has interfered with existing or planned arrangements and:

1. Must provide care for a child in elementary or secondary school (this includes children in grades K-12), and school and/or other normal childcare arrangements are not in effect due to the pandemic.
2. Must provide care for a younger child or children who are not of school age, and normal childcare arrangements are not in effect due to the pandemic.
3. Have other individuals (e.g., adult child or elderly parent with special needs) in the home requiring care and supervision and other caregivers are not available due to the pandemic.

PHASE 2

In Phase 2, telework is encouraged if feasible with business operations. Employees who choose to telework should notify their immediate supervisor. All employees, except as provided below, must return to normal work hours and the normal work week. Employees that are in a higher-risk category or pregnant, or those that live with someone in a higher-risk category or is pregnant, should still telework.

As provided for in Phase 1, employees with continuing dependent care responsibilities should still telework after notifying their direct supervisor. These employees may also continue to work expanded hours and expanded work week if on a Maxiflex or Flexitour schedule after notifying their immediate supervisor.

PHASE 3

In Phase 3, workplace status returns to the level that existed prior to instituting pandemic response actions. Health and safety protocols will be maintained to slow the spread of the virus. The availability

of mass transit will be evaluated. Where there is a significant impact, locations will develop a mitigation plan that could include workforce flexibilities or unscheduled telework.

Employees are expected to have dependent care issues resolved and be available to return to the workplace. If an employee has unresolved dependent care issues, they should work with their immediate supervisor about an extension of unscheduled telework and an expanded workday and workweek. The appropriate Regional Administrator, Assistant Administrator, Chief of Staff in the Administrator's Office or designee must approve any extension of unscheduled telework, work hours or workdays in Phase 3.

During Phase 3, social distancing considerations should be given to members of the vulnerable population who request such consideration.

Facility Guidance

Each facility should follow the EPA Facility Checklist, which includes guidelines for social distancing in common spaces. Information on social distancing in work areas will be provided by local management.

Entry Screening

EPA will utilize an employee self-assessment tool through Phase 2. Use of the tool will be evaluated prior to entering Phase 3.

Visitors

Visitor access to EPA facilities will vary by Phase:

- Phase 1 – no visitors will be allowed.
- Phase 2 – visitors are allowed for mission-essential reasons and must conduct a self-assessment prior to entering the facility.
- Phase 3 – no restrictions.

Travel Posture

Allowed travel will vary by Phase:

- Phase 1 – limited to essential travel only.
- Phase 2 – unrestricted but require management review.
- Phase 3 – normal operation.

Action Plan for COVID-19 Positive Cases

The Agency will implement its plan if an employee is diagnosed as COVID-19 positive or individual who was in a facility is diagnosed positive to trace and inform contacts.

Message

From: Szaro, Deb [Szaro.Deb@epa.gov]
Sent: 6/11/2020 11:45:46 AM
To: Vizian, Donna [Vizian.Donna@epa.gov]
Subject: RA talking points

Donna, these are the tps the DRAs prepared for the RAs. We'd appreciate receiving any comments you'd like to offer today, if possible. Thanks.

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Ex. 5 Deliberative Process (DP)

- We recommend the following approach for Phase 3 in a location until the spread of COVID-19 has been minimized, as determined by ORD:
  - Ex. 5 Deliberative Process (DP)

Message

From: Starfield, Lawrence [Starfield.Lawrence@epa.gov]
Sent: 7/15/2020 10:18:54 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]
Subject: RE: Phase 3 Reopening Plan

Thanks.

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Wednesday, July 15, 2020 1:59 PM
To: Starfield, Lawrence <Starfield.Lawrence@epa.gov>
Subject: RE: Phase 3 Reopening Plan

I am ok if you talk them through it

From: Starfield, Lawrence <Starfield.Lawrence@epa.gov>
Sent: Wednesday, July 15, 2020 1:57 PM
To: Vizian, Donna <Vizian.Donna@epa.gov>
Subject: RE: Phase 3 Reopening Plan

Donna -- When can we share this with ODs and Deputy ODs? I'd like to give them "some" advance time to review before it goes to all employees and the questions start.

Larry

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Wednesday, July 15, 2020 1:47 PM
To: Leadership_Assistant_Administrators <Leadership_Assistant_Administrators@epa.gov>; Leadership_Regional_Administrators <Leadership_Regional_Administrators@epa.gov>; Leadership_Deputy_Regional_Administrators <Leadership_Deputy_Regional_Administrators@epa.gov>; Leadership_Deputy_Assistant_Administrators <Leadership_Deputy_Assistant_Administrators@epa.gov>; Leadership_Associate_Administrators <Leadership_Associate_Administrators@epa.gov>
Subject: Phase 3 Reopening Plan

Hi Everyone,

I hope you are safe and well. Attached is the Revised Plan for Phase 3 that has been approved by Doug. We are working on a communication to the Agency, so I ask that you keep this close hold until it is released. I know there will be many questions. You should have received an invitation for a call at 1:15 tomorrow.

A few things to note:

- **Ex. 5 Deliberative Process (DP)**

Thanks
Donna

Message

From: Widener, Charles (Chuck) [Widener.Charles@epa.gov]
Sent: 6/11/2020 11:59:10 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]; Grantham, Nancy [Grantham.Nancy@epa.gov]
Subject: RE: Headquarters Office Operations and Return to the Workplace Guidance

Yes – sending the Administrator's message now.

Chuck Widener
Director, Office of Web Communications
Office of Public Affairs
US Environmental Protection Agency
1200 Pennsylvania Avenue, N.W.
Mail Code: 1703A, Washington, D.C. 20460
Tel: 202-564-8403 | widener.charles@epa.gov

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 11, 2020 7:56 PM
To: Widener, Charles (Chuck) <Widener.Charles@epa.gov>; Grantham, Nancy <Grantham.Nancy@epa.gov>
Subject: FW: Headquarters Office Operations and Return to the Workplace Guidance

Success. Will you send the Administrator's mailer now?

From: MassMailer <massmailer@epa.gov>
Sent: Thursday, June 11, 2020 7:53 PM
To: MassMailer <massmailer@epa.gov>
Subject: Headquarters Office Operations and Return to the Workplace Guidance

Colleagues,

As indicated in the Administrator's message on June 1, 2020, the Agency's plan to safely return to the office considers scientific data, state and local orders, and an evaluation of site-specific conditions. With communities expected to recover at different speeds, location-specific conditions are the driving decisions to ensure people are reoccupying our offices in a way that is safe while having the appropriate protective measures in place. I want to reiterate that our plan is to continue robust usage of unscheduled telework as we transition back to supporting in-office operations.

As mentioned in Administrator Wheeler's mass mailer, our Agency experts in the Office of Research and Development (ORD) have been providing information on the status of each gating criterion in the commuting area surrounding our facility locations each week. The review of 14-day trend data this week showed that the

National Capitol Region is meeting the gating criteria (see the attached chart demonstrating this trend downward). Also, as of Friday, May 29, 2020, Washington, DC, lifted its stay-at-home order, and Virginia and Maryland have gradually progressed in their plans to reopen their states—moving into Phase 1 (for the Northern Virginia Region) and Phase 2, respectively. Therefore, the National Capital Region (i.e., headquarters) is moving forward to begin its plan to bring employees back to our offices at the Federal Triangle Complex, Ronald Reagan Building, and Potomac Yard Building according to the information outlined in the EPA Return to the Workplace document.

Our phased return to normal operations will happen gradually, beginning with a 7-day closure effective close of business on Monday, June 15, 2020. This closure, as outlined in the EPA/CDC Cleaning and Disinfection Guidance, will render the virus inactive; and once we reopen, we will remain committed to keeping our facilities properly cleaned and sanitized. We are also working with GSA to ensure that our buildings are maintained by following CDC's guidance on optimum engineering controls for the building ventilation systems and CDC Guidance for Building Water Systems.

I want to provide you with information on what to expect as we move through the gating phases. We are instituting new procedures outlined below during the first two phases as we slowly return to the office. We are undertaking these measures in order to safeguard and prioritize the well-being of our employees. We believe that instituting CDC-recommended social distancing protocols, continuing to leverage telework and work schedule flexibilities, and tightly controlling access to EPA space will better protect our health and safety while ensuring that we are able to continue performing the important work of the Agency.

The Agency will continue to adjust and update its guidance, as appropriate, based on CDC recommendations as well as local guidance. Guidance on the new day-to-day procedures that will be in effect during Phase 1 and Phase 2 is provided below, as well as in the attached HQ plan. This information will be updated as more detailed information becomes available. I also encourage you to keep checking the EPA COVID-19 page for links to resources and helpful tips for employees.

Maintaining the health and safety of our workforce while fulfilling our mission responsibilities is our top priority. We understand you may have questions about reopening. We will share more information as it becomes available. In the meantime, please talk to your supervisor if you have questions about your circumstances.

Thank you for your continued dedication to our mission. Stay safe and be well.

Telework and Work Schedule Flexibilities	**Phase 1** - We encourage all employees to use unscheduled telework and will continue to offer the expanded work hours and workweek flexibilities for those on Maxiflex or Flexitour schedules. Facilities will be open, and employees have the option to return to the workplace. Employees who the CDC identifies as being at higher risk for severe illness from COVID-19 or pregnant women and those with household members in that population should continue to telework. **Phase 2** - We will continue to encourage all employees to use unscheduled telework, notifying their supervisor if they choose to do so. Facilities will be open, and employees have the option to return to the workplace. Employees who the CDC identifies as being at higher risk for severe illness from COVID-19, pregnant women, and those living with members that are part of these vulnerable populations should continue to telework. The expanded work hours and workweek flexibilities will continue to be available to those

	with dependent care issues and on a Maxiflex or Flexitour schedule. All other employees must return to normal work schedules.
Building Access	During Phase 1 and 2, facilities will be open, and employees have the option to return to the workplace. We ask that each employee who goes into the office self-screen by reviewing the self-assessment questionnaire prior to leaving their residence, and to not enter the building if they answer yes to any of the listed questions. The following restrictions for entry and exit, along with security modifications will apply at Headquarters buildings: • Entry and exit locations will be designated, and signage and markings on the floor will be posted in order to maximize social distancing. • EPA entry security screening locations will include the main entrances of each of the four WJ Clinton Buildings (North, South, East and West), RRB entrance on the side with the turnstiles, and the main entrance of PY. • Exit locations will include WJ Clinton West employee entrance/exit (opposite RRB), East employee entrance/exit (under the arch), the WJ Clinton courtyard entrances/exits, the WJ Clinton Pennsylvania Avenue entrance/exit, and RRB on the side opposite the turnstiles. The main entrance of PY will be marked with signage to create distinct entrance and exit areas. • The center turnstiles will be closed at the four WJC main lobby locations to promote social distancing. • In the event of an emergency, all building entrances and exits will be open and accessible for an exit. • Plexiglass partitions are being procured and placed in front of all guard desks and screening entry points. • Federal Protective Service Security Officers will follow the District of Columbia's Executive Order for returning to the workplace regarding wearing cloth face coverings. EPA employee IDs will not be touched upon entry at any HQ location and FPS Security Officers will not ask employees to remove cloth face coverings. • Signage will be posted at all entry points to remind employees and visitors about the employee self-assessment tool before presenting identification and proceeding through security screening.
Local Orders (face coverings)	The Mayor of the District of Columbia has issued an Order requiring face coverings when in public, and Virginia guidance also requires face coverings where social distancing cannot be maintained. Therefore, face coverings must be worn when inside the WJ Clinton Buildings (North, South, East and West), RRB and PY where social distancing cannot be maintained. Employees must continue to wear a face covering when in a common area inside the building (e.g., pantries, restrooms, hallways, etc.). Those seeking services (e.g., badging, IT services) must wear a face covering at the time of service regardless of local or state orders. A cloth face covering is not required when an employee is working alone in a private office; however, a cloth face covering or mask may be required when an employee is seated at their cubicle or workstation, if social distancing cannot be maintained due to the workstation location. We will notify you if the local order changes.

Social Distancing	Social distancing guidelines will be implemented and maintained between people throughout the facility. Employees should not congregate in these areas, including but not limited to: ▪ Entry and exit doors ▪ Lobbies and foyers ▪ Elevators and stairwells ▪ Hallways and corridors ▪ Restrooms ▪ Pantries, kitchen and break areas ▪ Photocopy and printer areas ▪ Open floor environments (e.g., labs, warehouses, etc.) Signage will be posted to notify staff of occupant limit, seating restrictions, or other restrictions throughout the facility. **Meeting Rooms**: Employees should use virtual meetings when possible. For in-person meetings, rooms will be labeled with a maximum capacity and used in accordance with social distancing best practices.
Visitor Access to Buildings	**Phase 1** - Facilities will be closed to visitors. **Phase 2** - Facilities are open to visitors for mission-essential work purposes only.
Work Travel	**Phase 1** - Travel will be limited to essential travel. If an employee is required to travel to ensure compliance with environmental laws and regulations that, if not otherwise done, could result in a detrimental impact to public health and the environment. Travel must be approved by the Senior Resource Official, or designee, prior to entering the travel authorization into Concur. **Phase 2** - Nonessential travel may resume with evaluation of state and local restrictions and requirements. As with all travel requests, supervisory approval is required.
Contact Tracing	Throughout all Phases, the Agency will utilize its guidance to notify and trace when an employee has tested positive for COVID-19.

Message

From: Eubanks, Kristy [Eubanks.Kristy@epa.gov]
Sent: 6/11/2020 5:25:21 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]
CC: Banister, Beverly [Banister.Beverly@epa.gov]
Subject: Reopening status of GA and Atlanta
Attachments: 05.28.20.02.pdf; 5_28_2020_Executive_Order_Q_A_GEORGIARESTAURANTS.pdf

Hi Donna,

Below is a table showing the reopening status on several areas. We attached the executive orders just as a point of reference. Please let us know if you have any questions. Thanks - Kristy

Kristy H. Eubanks
Acting Director
Mission Support Division
USEPA – Region 4
404-562-8039 (work)
Ex. 6 Personal Privacy (PP) (cell)

Entity	Reopening Status
Restaurants/Businesses	• Open with provisions: Beginning at midnight June 1 and ending at 11:59 p.m. June 15. • Restaurants and dining services that choose to open must mitigate the exposure of COVID-19 to customers and workforce using precautions listed in the May 28th Executive Order. • No more than ten (10) patrons should be allowed in the facility per 300 square feet of public space. • Many restaurants are focusing on call ahead and pick up services • Many Downtown Atlanta restaurants did not reopen as they service a large university student (Georgia State and Georgia Tech) and government population and restaurants had to meet 39 state mandated criteria to reopen. • Awaiting updates and more clarifications on June 15.
State and Local Government	• Georgia state and local offices are open but it is not business as usual. • Many state/local offices are exercising full telework through June 15 per the May 28 executive order. • Awaiting updates and more clarifications on June 15th.
Transit	• 61% of Region 4 employees take some form of transit - either via MARTA (rail and bus) or Cobb, Gwinnett, and GRTA (bus service). • Each transit entity is utilizing a revised schedule that impacts if certain routes are running and the times they run.

	• There are also limits on ridership, for example Cobb is only allowing 10 riders per 60 passenger (83% occupancy decrease) bus and Gwinnett is allowing 14 passengers on commuter buses (76% occupancy decrease). • MARTA is encouraging riders to not get on full buses, to wait for the next bus. They are also encouraging train passengers to seek out cars that are less full or wait for the next train.

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Thursday, June 11, 2020 11:31 AM
To: Banister, Beverly <Banister.Beverly@epa.gov>; Eubanks, Kristy <Eubanks.Kristy@epa.gov>
Subject: Reopening status of GA and Atlanta

GM – can you please send me a brief description of the reopening status – business, restaurants etc. Need ASAP thanks

THE STATE OF GEORGIA

EXECUTIVE ORDER

BY THE GOVERNOR:

REVIVING A HEALTHY GEORGIA

WHEREAS: On March 14, 2020, due to the impact of COVID-19 on the State of Georgia, I issued Executive Order No. 03.14.20.01, declaring a Public Health State of Emergency in Georgia; and

WHEREAS: The Georgia General Assembly concurred with Executive Order 03.14.20.01 by joint resolution on March 16, 2020; and

WHEREAS: On April 8, 2020, I renewed the Public Health State of Emergency until May 13, 2020 by issuing Executive Order 04.08.20.02; and

WHEREAS: On April 30, 2020, I renewed the Public Health State of Emergency until June 12, 2020 by issuing Executive Order 04.30.20.01; and

WHEREAS: Code Section 38-3-51(c)(4) vests the Governor with the power to perform and exercise such other functions, powers, and duties as may be deemed necessary to promote and secure the safety and protection of the civilian population; and

WHEREAS: Code Section 38-3-51(d)(1) vests the Governor with the power to suspend any regulatory statute prescribing the procedures for conduct of state business, or the orders, rules, or regulations of any state agency if strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay necessary action in coping with the emergency or disaster; and

WHEREAS: Code Sections 31-2A-4 and 31-12-4 vests the Department of Public Health with the power to segregate and isolate certain individuals with certain communicable diseases or conditions when said individuals' exposure to the general population is likely to endanger the health of others; and

WHEREAS: Corporations that are calling and holding meetings of shareholders pursuant to Code Sections 14-2-701 or 14-2-702 are required to deliver advance notice and meet other legal requirements under the laws of the State of Georgia, as well as the federal securities laws of the United States, in advance of convening such meetings; and

WHEREAS: In consultation with the Governor's Coronavirus Task Force and health and emergency preparedness officials, I have determined that the following actions are necessary and appropriate to protect the strength of Georgia's economy and provide for the health, safety, and welfare of Georgia's residents and visitors.

NOW, THEREFORE, PURSUANT TO THE AFOREMENTIONED GEORGIA LAW, CODE SECTION 38-3-51, AND THE AUTHORITY VESTED IN ME AS THE GOVERNOR OF THE STATE OF GEORGIA, IT IS HEREBY

I. GENERAL PROVISIONS

ORDERED: That unless otherwise noted, the provisions contained in this Order shall be effective from June 1, 2020 at 12:00 A.M. until June 15, 2020 at 11:59 P.M.

IT IS FURTHER

ORDERED: That all residents and visitors of the State of Georgia shall practice Social Distancing as defined herein and refrain from Gathering as defined herein.

IT IS FURTHER

ORDERED: That all residents and visitors of the State of Georgia are strongly encouraged to wear face coverings as practicable while outside their homes or place of residence, except when eating, drinking, or exercising outdoors.

IT IS FURTHER

ORDERED: All residents and visitors of the State of Georgia shall practice sanitation in accordance with the guidelines published by the Centers for Disease Control and Prevention.

IT IS FURTHER

ORDERED: That no business, establishment, corporation, non-profit corporation, organization, or county or municipal government shall allow Gatherings of persons. This provision shall not apply to

cohabitating persons, family units, or roommates residing together in private homes, whether inside or outside of their homes or place of residence. This provision shall also not apply to entities defined as "Critical Infrastructure."

II. DEFINITIONS

IT IS FURTHER

ORDERED: That the following definitions shall apply to this Order:

1. "Camper" shall mean any person that attends a Summer Camp as a participant. This provision shall specifically exclude those persons who volunteer or work at Summer Camps.
2. "Critical Infrastructure" shall include all Workers, businesses, establishments, corporations, non-profit corporations, and organizations included in versions 1.0, 2.0, and 3.0 of Guidance on Essential Critical Infrastructure Workers released by the U.S. Department of Homeland Security on March 19, 2020, March 28, 2020, and April 17, 2020, respectively. The term "Critical Infrastructure" shall also include those suppliers which provide essential goods and services to the Critical Infrastructure workforce as well as entities that provide legal services, home hospice, and non-profit corporations or non-profit organizations that offer food distribution or other health or mental health services.
3. "Essential Services" shall include those activities outlined below:
    A. Obtaining necessary supplies and services for family or household members, such as food and supplies for household consumption and use, medical supplies or medication, supplies and equipment needed to work from home, and products needed to maintain safety, sanitation, and essential maintenance of the home or residence. Preference should be given to online ordering, home delivery, and curbside pick-up services wherever possible as opposed to in-store shopping;
    B. Engaging in activities essential for the health and safety of family or household members;
    C. Seeking medical, behavioral health, or emergency services;
    D. Activities that may preserve the health and welfare of persons within this State;
    E. The transport, visitation, and regular care of family members and persons dependent on the services of others, and similar actions that ensure the welfare and

best interests of persons in the State of Georgia, specifically including the elderly, children, and disabled populations;

F. Children obtaining public internet access to fulfill educational obligations; and

G. Engaging in outdoor exercise activities so long as Social Distancing is practiced during such activities between all persons who are not occupants of the same household or residence.

4. "Gathering" shall mean more than twenty-five (25) persons physically present at a Single Location if, to be present, persons are required to stand or be seated within six (6) feet of any other person. Therefore, groups of more than twenty-five (25) people are permitted if their grouping is transitory or incidental, or if their grouping is the result of being spread across more than one Single Location.
5. "Hand Sanitizer" shall mean any hand antiseptic, hand rub, soap, or agent applied to the hands for the purpose of removing common pathogens.
6. "Necessary Travel" shall mean such travel as is required to conduct or participate in Essential Services or Critical Infrastructure as defined by this Order.
7. "Overnight Summer Camp" shall mean a Summer Camp where Campers stay overnight on the Summer Camp premises. This term shall not include those entities commonly referred to as "day camps."
8. "Personal Protective Equipment" shall mean surgical masks, N95 masks, respirators, other facemasks, protective gloves, protective clothing, protective garments, and shoe coverings.
9. "Restaurants and Dining Rooms" shall mean any entity defined as a "food service establishment" pursuant to Code Section 26-2-370(2).
10. "Shelter in Place" shall mean a person is required to remain in their home or place of residence and take every possible precaution to limit social interaction to prevent the spread or infection of COVID-19 to themselves or any other person, subject to the provisions and exceptions of this Order.
11. "Single Location" shall mean a space where all persons gathered cannot maintain at least six (6) feet of distance between themselves and any other person.
12. "Social Distancing" shall mean keeping space between yourself and other people outside of your home or place of residence. Persons practicing Social Distancing should stay at least six (6) feet from other people, avoid assembling in groups, avoid crowded places, and avoid large crowds. This provision shall not apply to cohabitating persons, family

units, or roommates residing together in private homes, whether inside or outside of their homes or place of residence.

13. "Summer Camp" shall mean any entity offering organized sessions of supervised recreational, athletic, or instructional activities held between typical school terms. This term shall include those entities commonly referred to as "day camps."
14. "Summer School" shall mean extended school year classes, credit recovery classes, and all other learning classes that are offered by schools or school districts between the 2019-2020 school year and the 2020-2021 school year.
15. "Symptoms of COVID-19" shall mean symptoms identified by the Centers for Disease Control and Prevention as symptoms of COVID-19 and shall include at least the following: fever or chills; cough; shortness of breath or difficulty breathing; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; and diarrhea.
16. "Worker" shall include employees, independent contractors, agents, volunteers, or other representatives of a business, establishment, corporation, non-profit corporation, organization, or other entity.

III. SHELTERING IN PLACE

IT IS FURTHER

ORDERED: That pursuant to Executive Order 04.30.20.01, this Section, titled "Sheltering in Place" shall be effective until Friday, June 12, 2020, at 11:59 P.M.

IT IS FURTHER

ORDERED: That all residents and visitors of the State of Georgia who meet the following criteria for higher risk of severe illness as defined by the Centers for Disease Control and Prevention are required to Shelter in Place within their homes or places of residence:

1. Those persons who are 65 years of age or older.
2. Those persons who live in a nursing home or long-term care facility, including inpatient hospice, assisted living communities, personal care homes, intermediate care homes, community living arrangements, and community integration homes.
3. Those persons who have chronic lung disease.
4. Those persons who have moderate to severe asthma.
5. Those persons who have severe heart disease.

6. Those persons who are immunocompromised. Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medication.
7. Those persons, of any age, with class III or severe obesity.
8. Those persons diagnosed with the following underlying medical conditions: diabetes, liver disease, and persons with chronic kidney disease undergoing dialysis.

IT IS FURTHER

ORDERED: That persons required to Shelter in Place shall be permitted to engage in the following activities:

1. Conducting or participating in Essential Services;
2. Performing Necessary Travel;
3. Engaging in gainful employment or the performance of, or travel to and from the performance of, minimum necessary activities to maintain the value of a business, establishment, corporation, non-profit corporation, or organization not classified as Critical Infrastructure; or
4. Working in or for Critical Infrastructure and being actively engaged in the performance of, or travel to and from, their respective employment.

IT IS FURTHER

ORDERED: That persons required to Shelter in Place shall not receive visitors, except as follows:

1. Visitors providing medical, behavioral health, or emergency services or medical supplies or medication, including home hospice;
2. Visitors providing support for the person to conduct activities of daily living or instrumental activities of daily living;
3. Visitors providing necessary supplies and services, such as food and supplies for household consumption and use, supplies and equipment needed to work from home, and products needed to maintain safety, sanitation, and essential maintenance of the home or residence; or
4. Visitors received during end-of-life circumstances.

To the extent practicable under the circumstances, visitors shall maintain a minimum distance of six (6) feet between themselves and all other occupants of the person's home or residence. Any visitors visiting for the sole purpose of delivering medication, supplies, or other tangible goods shall, to the extent practicable, deliver such

items in a manner that does not require in-person contact or require the deliverer to enter the person's home or residence.

IT IS FURTHER

ORDERED: That the provisions of this Order related to visitors listed in the immediately preceding paragraph shall be strictly enforced upon nursing homes or other long-term care facilities, including inpatient hospice, assisted living communities, personal care homes, intermediate care homes, community living arrangements, and community integration homes.

IT IS FURTHER

ORDERED: That an exception to any Shelter in Place requirement set forth hereunder applies in the event of an emergency. In such cases, persons are encouraged to leave their homes or residences and Shelter in Place in accordance with the rules included in this Order at a safe alternate location. Persons experiencing homelessness are urged to obtain shelter and contact governmental and other entities for assistance.

IV. RESTAURANTS & DINING SERVICES

IT IS FURTHER

ORDERED: That for the purposes of Section IV of this Order, titled "Restaurants & Dining Services," the term "Single Location" as used in the definition of "Gatherings" in Section I of this Order shall mean 300 square feet of public space. This formula shall only apply to patrons. Therefore, for restaurants, no more than ten (10) patrons should be allowed in the facility per 300 square feet of public space. In calculating the total number of public space square feet, such calculation shall include waiting and bar areas as well as patios or any outdoor dining space, if any, but shall not include hallways, restrooms, and spaces closed to patrons.

IT IS FURTHER

ORDERED: That all Restaurants and Dining Rooms as well as all banquet facilities, private event facilities, and private reception venues where food is served that operate during the effective dates of this Order ***shall*** implement measures which mitigate the exposure and spread of COVID-19 among its patrons and workforce. Such measures ***shall*** include the following:

1. Screen and evaluate Workers who exhibit Symptoms of COVID-19;
2. Require Workers who exhibit Symptoms of COVID-19 to not report to work or to seek medical attention. Per existing U.S. Food and Drug Administration Food Code requirements, Workers who are sick should remain home. If a Worker becomes ill or presents Symptoms of COVID-19 at work, the operator should identify the Worker's condition during a pre-work screening and send the Worker home. Restaurants shall create, maintain, and follow established policies regarding when Workers who have become ill are permitted to return to work. A Worker with known or suspected COVID-19 must follow Centers for Disease Control and Prevention guidelines to self-isolate for at least ten (10) days after onset of Symptoms of COVID-19 and end isolation only after Symptoms of COVID-19 have improved and the Worker has been fever-free and/or free of Symptoms of COVID-19 for three (3) consecutive days without medication before returning to work;
3. Implement teleworking for all possible Workers;
4. Implement staggered shifts for all possible Workers;
5. Hold all meetings and conferences virtually, whenever possible;
6. Train all Workers on the importance and expectation of increased frequency of handwashing, the use of Hand Sanitizers with at least 60% alcohol, and provide clear instruction to avoid touching hands to face;
7. Require all Workers to wear face coverings at all times. Workers may also wear face shields in addition to their face coverings. Such face coverings and face shields shall be cleaned or replaced daily;
8. Discourage Workers from using other Workers' phones, desks, offices, or other work tools and equipment;
9. Where possible, stagger workstations to avoid Workers standing adjacent to one another or next to each other. Where six (6) feet of separation is not possible, consider spacing options that include other mitigation efforts with increased frequency of cleaning and sanitizing surfaces;
10. Establish a limit for the maximum number of Workers permitted in Worker breakrooms to reduce contact;
11. Prohibit handshaking and other unnecessary person-to-person contact in the workplace;
12. Enforce Social Distancing of non-cohabitating persons while present on such entity's leased or owned property;
13. Increase physical space between Workers and patrons;
14. Limit contact between Workers and patrons;
15. Discard all food items that are out of date;

16. Discontinue use of salad bars and buffets, unless the salad bar or buffet is being used for cafeteria style service where a Worker is responsible for serving the patron, handling the utensils, and ensuring proper distancing in lines;
17. If providing a "grab and go" service, stock coolers to no more than minimum levels;
18. Ensure the Food Safety Manager certification of the person in charge is up-to-date and provide food handler training to refresh Workers;
19. Thoroughly detail, clean, and sanitize the entire facility prior to resuming dine-in services and continue to do so regularly, focusing such cleaning and sanitation on high contact areas that would be touched by Workers and/or patrons;
20. Between diners, clean and sanitize table condiments, digital ordering devices, check presenters, self-service areas, tabletops, and commonly touched areas, and discard single use items;
21. Use rolled silverware and eliminate table presets;
22. Remove items from self-service drink, condiment, utensil, and tableware stations and have Workers provide such items to patrons directly wherever practicable;
23. The use of disposable paper menus is strongly encouraged, which should be discarded after each patron use. Otherwise, businesses subject to this Section shall clean and sanitize reusable menus between each use by a patron. Non-touch menus are also acceptable for use;
24. Clean and sanitize restrooms regularly, check restrooms based on the frequency of use, and always ensure adequate supply of soap and paper towels;
25. Implement procedures to increase cleaning and sanitizing frequency of surfaces in the back-of-house. Avoid all food contact surfaces when using disinfectants;
26. Verify that ware-washing machines are operating at the required wash and rinse temperatures and with the appropriate detergents and sanitizers;
27. Update floor plans for common dining areas, redesigning seating arrangements to ensure at least six (6) feet of separation from seating to seating. Utilize physical barriers on booth seating when available to ensure Social Distancing;
28. Limit party size at tables to no more than ten (10);
29. Where practical, consider a reservations-only business model or call-ahead seating;
30. Remind third-party delivery drivers and any suppliers of your internal distancing requirements;
31. Post signage on entrances that no one with Symptoms of COVID-19 is permitted in the facility;

32. Where practicable, physical barriers such as partitions or Plexiglas at registers should be used;
33. Use technological solutions where possible to reduce person-to-person interaction: mobile ordering, mobile access to menus to plan, text on arrival for seating, and contactless payment options;
34. Provide Hand Sanitizer for use by patrons, including contactless hand sanitizing stations when available;
35. Do not allow patrons to congregate in waiting areas or bar areas. Design a process to ensure patron separation while waiting to be seated that can include floor markings, outdoor distancing, or waiting in cars;
36. If possible, use an exit from the facility separate from the entrance;
37. Mark ingress/egress to and from restrooms to establish paths that mitigate proximity for patrons and Workers;
38. Where practicable, take-out and curbside pick-up services should be prioritized over dine-in services; and
39. All restaurant or dining room playgrounds shall be closed.

IT IS FURTHER

ORDERED: That none of the provisions of Section IV of this Order, titled "Restaurants & Dining Services," shall apply to the operation of dine-in services in hospitals, health care facilities, nursing homes, or other long-term care facilities, but such facilities should implement measures to prevent the spread of COVID-19 if possible.

IT IS FURTHER

ORDERED: That the routine inspection timelines under Georgia Administrative Rule 511-6-1-.10(2) may be extended by the Georgia Department of Public Health by one hundred and twenty (120) days for any permit holder of a food service establishment maintaining an "A" food safety grade for any such food service establishment which was scheduled to have a routine inspection at any time between March 14, 2020 and September 10, 2020.

IT IS FURTHER

ORDERED: To the extent that the provisions of Section IV of this Order, titled "Restaurants & Dining Services," conflict with the provisions of Section V of this Order, titled "Industry & Commerce," the provisions of Section IV shall control.

V. INDUSTRY, COMMERCE, ORGANIZATIONS, & NON-PROFITS

IT IS FURTHER

ORDERED: That the Georgia Department of Economic Development is authorized to issue guidance to any business, corporation, organization, or industry trade group regarding its status as Critical Infrastructure. This guidance shall not require a finding of fact but shall be in writing and shall be considered a final agency action for the purpose of proceedings under Code Section 50-13-19.

IT IS FURTHER

ORDERED: Critical Infrastructure that continue in-person operation during the effective dates of this Order ***shall*** implement measures which mitigate the exposure and spread of COVID-19. Such measures ***may*** include, but shall not be limited to the following, which shall be implemented to the maximum extent practicable:

1. Screening and evaluating Workers who exhibit Symptoms of COVID-19;
2. Requiring Workers who exhibit Symptoms of COVID-19 to not report to work or to seek medical attention;
3. Enhancing sanitation of the workplace as appropriate;
4. Disinfecting common surfaces regularly;
5. Requiring handwashing or sanitation by Workers at appropriate places within the business location;
6. Prohibiting Gatherings of Workers during working hours;
7. Permitting Workers to take breaks and lunch outside, in their office or personal workspace, or in such other areas where proper Social Distancing is attainable;
8. Implementing teleworking for all possible Workers;
9. Implementing staggered shifts for all possible Workers;
10. Holding all meetings and conferences virtually, whenever possible;
11. Delivering intangible services remotely, whenever possible;
12. Discouraging Workers from using other Workers' phones, desks, offices, or other work tools and equipment;
13. Prohibiting handshaking and other unnecessary person-to-person contact in the workplace;
14. If in use, open sales registers must be at least six (6) feet apart;
15. Point of sale equipment, including PIN entry devices and signature pads, should be frequently cleaned and sanitized; and
16. Placing notices that encourage hand hygiene at the entrance to the workplace and in other workplace areas where they are likely to be seen.

IT IS FURTHER

ORDERED: That all businesses, establishments, corporations, non-profit corporations, or organizations that are *not* Critical Infrastructure that continue in-person operations during the effective dates of this Order ***shall*** implement measures which mitigate the exposure and spread of COVID-19 among its workforce. Such measures ***shall*** include the following:

1. Screening and evaluating Workers who exhibit Symptoms of COVID-19;
2. Posting a sign on the front of the facility stating that individuals who have Symptoms of COVID-19 shall not enter the store;
3. Requiring Workers who exhibit Symptoms of COVID-19 to not report to work or to seek medical attention;
4. Enhancing sanitation as appropriate;
5. Disinfecting common surfaces regularly;
6. Requiring handwashing or sanitation at appropriate places within the location;
7. Prohibiting Gatherings during hours of operation;
8. Permitting Workers to take breaks and meals outside, in their office or personal workspace, or in such other areas where proper Social Distancing is attainable;
9. Implementing teleworking as practicable;
10. Implementing staggered shifts as practicable;
11. Holding all meetings and conferences virtually as practicable;
12. Delivering intangible services remotely as practicable;
13. Discouraging use of other Worker's phones, desks, offices, or other tools and equipment;
14. Prohibiting handshaking and unnecessary person-to-person contact;
15. Placing notices that encourage hand hygiene at the entrance to the facility and in other areas where they are likely to be seen;
16. Enforcing Social Distancing of non-cohabitating persons while present on such entity's leased or owned property;
17. For retailers and service providers, providing for alternative points of sale outside of buildings, including curbside pick-up or delivery of products and/or services if an alternative point of sale is permitted under Georgia law;
18. For retailers and service providers, open sales registers must be at least six (6) feet apart;
19. Point of sale equipment, including PIN entry devices and signature pads, should be frequently cleaned and sanitized;
20. Increasing physical space between Workers and patrons; and
21. If the entity engages volunteers or has members of the public participate in activities, prohibiting volunteering or participation in activities for persons diagnosed with COVID-

19, having exhibited Symptoms of COVID-19, or having had contact with a person that has or is suspected to have COVID-19 within the past fourteen (14) days.

IT IS FURTHER

ORDERED: That Critical Infrastructure and all other businesses, establishments, corporations, non-profit corporations, or organizations that continue in-person operation during the effective dates of this Order ***should*** implement the following measures if practicable:

1. Providing Personal Protective Equipment as available and appropriate to the function and location of the Worker within the business location;
2. Providing disinfectant and sanitation products for Workers to clean their workspace, equipment, and tools; and
3. Increasing physical space between Workers' worksites to at least six (6) feet.

IT IS FURTHER

ORDERED: That all live performance venues ***shall not*** engage in in-person operations and shall remain closed to the public while this Order is in effect.

IT IS FURTHER

ORDERED: That all retail businesses, including Food Establishments (such as retail and wholesale grocery stores), as defined by Ga. Comp. R. & Regs. r. 40-7-1-.02 but not to include food processing plants or wholesale sandwich and salad manufacturers, ***shall*** implement additional measures to prevent the spread of COVID-19, as practicable. Such measures ***shall*** include:

1. Limiting the number of patrons inside the store to 50% of fire capacity occupancy of the entire store or eight (8) patrons per 1,000 square feet;
2. Encouraging patrons to use Hand Sanitizer upon entering;
3. Encouraging non-cash payments when possible;
4. Sanitizing entrance and exit doors at least three times per day;
5. Encouraging Workers to report any safety and health concerns to the employer; and
6. Installing protective screens or other mitigation measures where patron-Worker interactions are likely.

IT IS FURTHER

ORDERED: That in addition to the applicable requirements above, Food Establishments (such as retail and wholesale grocery stores), as

defined by Ga. Comp. R. & Regs. r. 40-7-1-.02 but not to include food processing plants or wholesale sandwich and salad manufacturers, ***shall*** implement additional measures to those listed above as practicable. Such measures ***may*** include, but shall not be limited to the following, which shall be implemented to the maximum extent practicable:

1. Scheduling specific hours of operation for vulnerable populations to shop;
2. Reducing store hours to allow for increased cleaning and sanitation while the store is closed;
3. Enacting policies and procedures to encourage Social Distancing for patrons and Workers. Measures may include:
    a. Protective Plexiglass screens at service counters and at cash registers;
    b. Decals on the floor or aisles with messaging on Social Distancing;
    c. Signs throughout the store giving visuals on Social Distancing;
    d. Limited occupancy if store becomes too crowded; and
    e. Use of one-way aisles;
4. Providing Personal Protective Equipment as available and appropriate to the function and location of the Worker within the business location;
5. Encouraging patrons to wear face coverings;
6. Utilizing in-store messaging to educate and remind patrons and Workers on recommended hygiene and Social Distancing;
7. Discontinuing sampling or cooking stations;
8. Closing self-serve salad bars and buffets;
9. Adding additional Workers to specifically oversee increased sanitation of grocery carts, and other high-touch areas such as door handles, point of sales equipment, conveyor belts, and other surfaces;
10. Checking restrooms regularly, cleaning and sanitizing based on frequency of use, and always ensuring adequate supply of soap and paper towels;
11. Allowing time for frequent handwashing for Workers, including cashiers, that interact directly with patrons;
12. Increasing or add hand sanitizing stations around stores for patrons and Workers; and
13. Procuring options with third-party cleaning companies to assist with the increased cleaning demands as needed.

IT IS FURTHER

ORDERED: That in addition to the applicable requirements above, gyms and fitness centers ***shall*** implement additional measures to prevent the spread of COVID-19, as practicable. Such measures ***shall*** include:

1. Placing signage at any entrance to instruct patrons that they cannot enter if they have been diagnosed with COVID-19, had Symptoms of COVID-19, or had contact with a person that has or is suspected to have COVID-19;
2. Placing signage at any entrance and throughout the facility to instruct patrons of the enhanced sanitation procedures, Social Distancing requirements, and other instructions and limitations, as applicable, set forth below;
3. If Workers are present at the gym or fitness center, screening patrons at the entrance and prohibiting entrance for patrons exhibiting Symptoms of COVID-19;
4. Limiting occupancy to enforce Social Distancing requirements and to prohibit Gatherings;
5. Utilizing contactless forms of patron check-in;
6. Providing Hand Sanitizer stations as available for patrons;
7. Providing antibacterial sanitation wipes as available at or near each piece of equipment and requiring users to wipe down the equipment before and after use;
8. Requiring Workers, if any, to patrol patron areas to enforce the equipment wipe-down policy and conduct additional cleanings during times when equipment is not being used;
9. Limiting use of cardio machines to every other machine or distancing machines to maintain acceptable Social Distancing between users;
10. Enforcing Social Distancing and prohibiting congregating between non-cohabitating patrons, especially in pools, group fitness classes, and areas where group sports regularly occur;
11. Encouraging patrons to conduct their workout and exit the facility without unnecessary delay;
12. Complying with the regulations for "Childcare Facilities" included in Section VII of this Order titled "Children" if childcare services are provided;
13. Closing the following facilities and equipment within a gym or fitness center: hot tubs, saunas, and steam rooms;
14. Requiring patrons to spray showers with a provided cleaning spray after use;
15. In addition to the regular cleaning schedule, cleaning and sanitizing high touch surfaces, bathrooms, and locker rooms regularly throughout hours of operation;
16. Prohibiting patrons from sharing equipment without cleaning and sanitizing between uses;
17. Practicing Social Distancing between trainers and patrons as practicable;

18. Requiring no less than ten (10) feet of distance between patrons participating in group fitness classes; and
19. Requiring rooms and equipment used for group fitness classes to be disinfected between classes.

IT IS FURTHER

ORDERED: That in addition to the applicable requirements above, body art studios permitted pursuant to Code Section 31-40-2, businesses registered pursuant to Code Sections 43-10-11 and 43-10-18, estheticians as defined by Code Section 43-10-1(8), hair designers as defined by Code Section 43-10-1(9), persons licensed to practice massage therapy pursuant to Code Section 43-24A-8, and tanning facilities as defined by Code Section 31-38-1(6) ***shall*** implement additional measures to prevent the spread of COVID-19, as practicable. Such measures ***shall*** include:

1. Providing services by appointment only. Walk-in patrons should not be allowed;
2. Patrons should be required to sanitize their hands upon entering the facility and before any treatment;
3. Providing Hand Sanitizer or sanitization wipes to patrons upon arrival;
4. Posting signs at the entrance and at eye-level at each workstation stating that any patron who has Symptoms of COVID-19 must reschedule their appointment;
5. Allowing only one patron per service provider in the business at any one time;
6. Allowing one parent to be within a facility if their minor child is receiving a haircut;
7. Requiring patrons to wait in their vehicle or outside the establishment until the service provider is ready, or patrons may wait in a waiting area inside the facility provided that all seating within the waiting area is spaced so that no waiting patron is seated within six (6) feet of any other person and all waiting patrons are required to wear face coverings;
8. Staggering use of every-other workstation or spacing workstations more than ten (10) feet apart, whichever option is practicable given the facility's configuration;
9. Staggering work schedules so that no more than 50% of the normal number of Workers providing services will be in the business at a time;
10. Requiring all Workers to wear Personal Protective Equipment as available and appropriate to the function and location of the Worker within the business location;
11. Sanitizing all equipment, chairs, and tables used by Workers and patrons between each client visit;

12. Utilizing disposable materials and supplies as much as practicable according to state rules and regulations; and
13. Training all Workers on additional measures both verbally and in writing.

IT IS FURTHER

ORDERED: That in addition to the applicable requirements above, indoor movie theaters and cinemas choosing to operate during the effective dates of this Order ***shall*** implement additional measures to prevent the spread of COVID-19. Such measures ***shall*** include:

1. Each party of patrons must be seated at least six (6) feet apart. No party seated together may number more than ten (10) individuals;
2. At least one usher must be used in each theater room before and at some point during each showing to ensure that proper Social Distancing protocol is enforced;
3. Seats, armrests, handrails, doors, doorknobs, and door handles in each theater must be thoroughly sanitized before and after each showing;
4. Tape must be applied to floors at ticket counters and concession stands to enforce proper Social Distancing protocol for patrons who are waiting in line;
5. Restrooms must be cleaned and disinfected regularly, and touchpoints must be cleaned and sanitized no less than once per hour;
6. Food service areas must adhere to the same guidelines set forth in Section IV, titled "Restaurants & Dining Services", above;
7. Party rooms located at theaters may not host parties or Gatherings; and
8. Playgrounds, if any, must be closed.

IT IS FURTHER

ORDERED: That in addition to the applicable requirements above, bowling alleys choosing to operate during the effective dates of this Order ***shall*** implement additional measures to prevent the spread of COVID-19. Such measures ***shall*** include:

1. Placing signage at entrance and throughout the facility to instruct patrons of Social Distancing requirements and other instructions and limitations, as applicable;
2. Providing Hand Sanitizer stations for patrons throughout the facility;
3. Food service areas must adhere to the same guidelines set forth in Section IV, titled "Restaurants & Dining Services", above;

4. Tape must be applied to floors at ticket counters and rental stations to enforce proper Social Distancing protocol for patrons who are waiting in line;
5. Removing items from all self-service bowling ball, bowling shoe, and other bowling accessory stations and having Workers provide such items to patrons directly;
6. Limiting the number of patrons per lane to groups of ten (10) or less;
7. Staggering use of lanes so that only every other lane or every third lane is in use to maintain proper Social Distancing between groups of patrons. Each party of patrons must be seated at least six (6) feet apart;
8. Score keeping machines, ball returns, tables, seats, and other fixtures at each bowling lane must be thoroughly sanitized before and after each use;
9. Bowling balls and bowling shoes must be thoroughly sanitized before and after each use;
10. Party rooms located at bowling alleys may not host parties or Gatherings; and
11. Closing playgrounds, if any.

IT IS FURTHER

ORDERED: That in addition to the applicable requirements above for non-Critical Infrastructure, businesses which possess a license to operate as or otherwise meet the definition of "bar" as defined by Code Section 3-1-2(2.1) ***shall*** implement additional measures to prevent the spread of COVID-19, as practicable. Such measures ***shall*** include:

1. Screening and evaluating Workers who exhibit Symptoms of COVID-19;
2. Requiring Workers who exhibit Symptoms of COVID-19 to not report to work or to seek medical attention. Per existing U.S. Food and Drug Administration Food Code requirements, Workers who are sick should remain home. If a Worker becomes ill or presents Symptoms of COVID-19, the operator should identify the Worker's condition during a pre-work screening and send the Worker home. Bars shall create, maintain, and follow established policies regarding when Workers who have become ill are permitted to return to work. A Worker with known or suspected COVID-19 must follow Centers for Disease Control and Prevention guidelines to self-isolate for at least ten (10) days after onset of Symptoms of COVID-19 and end isolation only after Symptoms of COVID-19 have improved and the Worker has been free of Symptoms of COVID-19 for three (3) consecutive days without medication before returning to work;

3. Limiting the number of total persons inside the bar to twenty-five (25) persons or thirty-five percent (35%) of total listed fire capacity occupancy of the entire bar, whichever is greater;
4. Implementing teleworking for all possible Workers;
5. Implementing staggered shifts for all possible Workers;
6. Holding all meetings and conferences virtually, whenever possible;
7. Training all Workers on the importance and expectation of increased frequency of handwashing, the use of Hand Sanitizers with at least 60% alcohol, and provide clear instruction to avoid touching hands to face;
8. Requiring all Workers to wear face coverings at all times. Workers may also wear face shields in addition to their face coverings. Such face coverings and face shields shall be cleaned or replaced daily;
9. Discouraging Workers from using other Workers' phones, workstations, or other work tools and equipment;
10. Where possible, staggering workstations to avoid Workers standing adjacent to one another or next to each other. Where six (6) feet of separation is not possible, consider spacing options that include other mitigation efforts with increased frequency of cleaning and sanitizing surfaces;
11. Establishing a limit for the maximum number of Workers permitted in Worker breakrooms to reduce contact;
12. Prohibiting handshaking and other unnecessary person-to-person contact in the workplace;
13. Enforcing Social Distancing of non-cohabitating persons while present on such entity's leased or owned property;
14. Increasing physical space between Workers and patrons;
15. Limiting contact between Workers and patrons;
16. Thoroughly detailing, cleaning, and sanitizing the entire facility prior to reopening and continue to do so regularly, focusing such cleaning and sanitation on high contact areas that would be touched by Workers and/or patrons;
17. Between patrons, cleaning and sanitizing tables, digital ordering devices, check presenters, self-service areas, tabletops, and commonly touched areas, and discarding single use items;
18. Removing any self-service items and have Workers provide such items to patrons directly wherever practicable;
19. Requiring the use of disposable paper menus, if applicable, and discarding such menus after each patron use. Non-touch menus are also acceptable for use;
20. Cleaning and sanitizing restrooms regularly, checking restrooms based on the frequency of use, and always ensuring adequate supply of soap and paper towels;

21. Implementing procedures to increase cleaning and sanitizing frequency of surfaces;
22. Verifying that ware-washing machines are operating at the required wash and rinse temperatures and with the appropriate detergents and sanitizers;
23. Establishing seating areas for patrons to discourage loitering at the bar or in commonly trafficked areas;
24. Providing service only to seated patrons, or, if not applicable, to patrons in designated areas that are practicing Social Distancing;
25. Updating floor plans for common service areas, redesigning seating arrangements to ensure at least six (6) feet of separation from seating to seating. Utilizing physical barriers on booth seating when available to ensure Social Distancing;
26. Limiting party size at tables to no more than six (6) patrons;
27. Where practical, considering a reservations-only business model or call-ahead seating;
28. Posting signage on entrances that no one with Symptoms of COVID-19 is permitted in the facility;
29. Where practicable, physical barriers such as partitions or Plexiglas at registers should be used;
30. Using technological solutions where possible to reduce person-to-person interaction: mobile ordering, mobile access to menus to plan, text on arrival for seating, and contactless payment options;
31. Providing Hand Sanitizer for use by patrons, including contactless hand sanitizing stations when available;
32. Preventing patrons from congregating; designing a process to ensure patron separation that can include floor markings or outdoor distancing;
33. If possible, using an exit from the facility separate from the entrance;
34. Marking ingress/egress to and from restrooms to establish paths that mitigate proximity for patrons and Workers;
35. Preventing activities that enable close human contact;
36. Establishing pathways for patrons' ingress and egress and ensuring that they are clear and unobstructed;
37. Setting up hand sanitizing stations at every entrance to the establishment and encouraging patrons to use Hand Sanitizer upon entering;
38. Requiring Workers to wash or sanitize their hands upon entering the establishment, and between interactions with patrons; and
39. Sanitizing the bar at least twice daily before opening and after closing.

IT IS FURTHER

ORDERED: That professional sports teams and professional sports organizations that engage in practices or other in-person operations during the effective dates of this Order ***shall*** operate solely pursuant to the rules or guidelines that have been promulgated or approved by the respective professional league of the sport. All amateur sports teams and amateur sports organizations that continue in-person operation during the effective dates of this Order ***shall*** adhere to the guidelines for non-Critical Infrastructure organizations listed above. Any previous executive order or departmental rule which would prevent professional sports teams, professional sports organizations, amateur sports teams, and amateur sports organizations from operating or operating in a manner inconsistent with the above requirements is hereby suspended.

IT IS FURTHER

ORDERED: That operators of amusement rides as defined by Code Section 25-15-51, traveling carnivals, water parks, circuses, and other temporary amusement rides shall not begin operation until June 12, 2020.

IT IS FURTHER

ORDERED: That in addition to the applicable requirements above for non-Critical Infrastructure, operators of amusement rides as defined by Code Section 25-15-51, traveling carnivals, water parks, circuses, and other temporary amusement rides operating during the effective dates of this Order ***shall*** implement additional measures to prevent the spread of COVID-19. Such measures ***shall*** include:

1. Enforcing social distancing at all times;
2. Increasing physical space between Workers and patrons;
3. Limiting contact between Workers and patrons;
4. Providing online training programs for workers instructing them on how to stay safe and keep patrons safe;
5. Providing workers with Personal Protective Equipment, as appropriate;
6. Requiring Workers to wear face coverings at all times;
7. Other than at water parks, encouraging patrons to wear face coverings at all times when they are not experiencing a ride or an attraction;
8. Utilizing touch-free or contactless payment options when possible;
9. Limiting occupancy on the premises to allow for patrons to abide by the Gathering ban at all times;

10. Prohibiting parties from entering when at least one patron in the party is exhibiting Symptoms of COVID-19;
11. Communicating new operational procedures to guests prior to arrival, on the attraction's website, and through social media to establish expectations and instill confidence, including:
    i. Identifying Symptoms of COVID-19;
    ii. Notifying patrons that if anyone in their party is experiencing Symptoms of COVID-19, the entire party will be denied entry;
    iii. Directives on wearing masks/ face coverings for employees and guests;
    iv. Social Distancing guidelines;
    v. Capacity limits that facilitate Social Distancing;
    vi. Enhanced cleaning and sanitization protocols;
    vii. Use of temperature checks/thermal scanning cameras; and
    viii. Procedures for isolating and seeking medical assistance for a patron or worker who may become ill on the premises.
12. Establishing uniform entrances where patrons are screened;
13. Prohibiting entrance of patrons exhibiting Symptoms of COVID-19;
14. Placing signage at any entrance to instruct patrons that they cannot enter if they have been diagnosed with COVID-19, had Symptoms of COVID-19, or had contact with a person that has or is suspected to have COVID-19 within the past fourteen (14) days;
15. Implementing processes to perform contactless security checks, as appropriate;
16. Reducing face-to-face purchase transactions when possible;
17. Removing any self-service items and have Workers provide such items to patrons directly wherever practicable;
18. Placing acrylic or other types of barriers or screens in areas where there is frequent patron-Worker contact;
19. Placing signs that remind patrons to adhere to the guidelines published by the Centers for Disease Control and Prevention to prevent the spread of COVID-19;
20. Requiring Workers to monitor queues and enforce Social Distancing and prevent Gatherings;
21. Encouraging the use of Hand Sanitizer by patrons at the entrance of the premises and the entrance to all ride or attraction queues;
22. Cleaning or sanitizing the contact surfaces on any ride or attraction after each patron's use;
23. Reducing the number of patrons per ride or attraction in the following manner:

i. For open-air rides where patrons are arranged in rows, such as roller coasters, log flumes, train rides, and similar types of rides and attractions, only allowing cohabitating persons to be seated on the same row and only seating every other row;
ii. For open-air rides where patrons are arranged in groups, such as free-fall rides, rafting rides, and other similar types of rides and attractions, seating cohabitating persons adjacent to each other and providing at least six (6) feet between non-cohabitating groups or patrons;
iii. For open-air rides where patrons are seated in cars, such as bumper cars, sky lifts, classic Ferris wheels, swing rides, and similar types of rides and attractions, only allowing cohabitating persons to be seated together in each car;
iv. For open-air rides where patrons are seated in an interspersed manner, such as carousels and similar types of rides and attractions, seating patrons so that there is at least six (6) feet between non-cohabitating patrons;
v. For closed car rides, such as monorails, gondola-style Ferris wheels, and similar types of rides and attractions, only allowing cohabitating persons to be seated together in each car or unit; and
vi. For self-guided rides where enforcing Social Distancing is not practicable and there are surfaces subject to multiple contacts, such as fun houses, ball pits, jump-arounds, haunted houses, and similar types of rides and attractions, closing such rides or attractions unless Social Distancing can be enforced and the ride or attraction can be sanitized between groups of participants.

24. Reconfiguring queues so that patrons must adhere to Social Distancing while waiting on a ride or attraction;
25. Closing live performance venues, if any, and other rides or attractions where Social Distancing cannot be effectively managed;
26. Recognizing that it may not be possible to open some attractions if Social Distancing and sanitation protocols cannot be implemented;
27. Reconfiguring locker arrangements or availability to allow for Social Distancing;
28. Sanitizing lockers between each use;
29. Reconfiguring seating and lounge areas to allow for Social Distancing;
30. Cleaning and sanitizing restrooms regularly, checking

restrooms based on the frequency of use, and ensuring adequate supply of soap and paper towels at all times;

31. Implementing procedures to increase cleaning and sanitizing frequency of surfaces;
32. Food service areas must adhere to the same guidelines set forth in Section IV of this Order, titled "Restaurants & Dining Services;" and
33. Water parks and water amusement rides shall implement the following additional measures:
    i. Ensuring pool water is treated in accordance with Georgia Department of Public Health and applicable county pool ordinance or Boards of Health regulations;
    ii. Utilizing a timed or controlled entry system to limit patron distancing in pools to allow for Social Distancing and have Workers regularly monitor capacity;
    iii. Not opening wave pools and other rides or attractions where Social Distancing cannot be effectively managed; and
    iv. Following applicable guidance from the Georgia Department of Public Health and Centers for Disease Control and Prevention on managing public swimming pools.

IT IS FURTHER

ORDERED: That in instances where persons are working outdoors without regular contact with other persons, such as delivery services, contractors, landscape businesses, and agricultural industry services, such persons ***shall*** only be required to practice Social Distancing and implement sanitation processes in accordance with the guidelines published by the Centers for Disease Control and Prevention.

VI. HEALTHCARE

IT IS FURTHER

ORDERED: That any person, service, or entity delivering healthcare during the effective dates of this Order shall adhere to the guidelines listed in Section V for Critical Infrastructure in addition to the guidelines listed in this Section.

IT IS FURTHER

ORDERED: That in addition to compliance with the guidelines for Critical Infrastructure, dental practices and clinics that continue in-person operation during the effective dates of this Order ***shall*** adhere to the American Dental Association's Interim Guidance for Minimizing Risk of COVID-19 Transmission and Interim Mask and Face Shield Guidelines. Any previous Executive Order or rule which would prevent dental practices and clinics from providing the full scope of their services subject to the above requirements is hereby suspended.

IT IS FURTHER

ORDERED: That in addition to compliance with the guidelines for Critical Infrastructure, licensed optometrists and their Workers that continue in-person operation during the effective dates of this Order ***shall*** adhere to the American Optometric Association's Practice Reactivation Preparedness Guide and the Georgia Optometric Association's COVID-19 guidelines for practices issued March 17, 2020 and updated April 20, 2020. Any previous Executive Order or rule which would prevent optometrists from providing the full scope of their services subject to the above requirements is hereby suspended.

IT IS FURTHER

ORDERED: That in addition to compliance with the guidelines for Critical Infrastructure, licensed opticians and their Workers that continue in-person operation during the effective dates of this Order ***shall*** adhere to the Centers for Disease Control and Prevention's Recommendations for Office Disinfection and Recommendations for Employers. Any previous Executive Order or rule which would prevent opticians from providing the full scope of their services subject to the above requirements is hereby suspended.

IT IS FURTHER

ORDERED: That in addition to compliance with the guidelines for Critical Infrastructure, Ambulatory Surgical Centers that continue in-person operation during the effective dates of this Order ***shall*** implement additional measures to prevent the spread of COVID-19 as practicable. Such measures ***may*** include, but shall not be limited to the following, which shall be implemented to the maximum extent practicable:

1. Screening patients before visits and monitoring their health prior to starting surgery as part of the pre-operative procedure;
2. Requiring Workers to self-monitor and screen for Symptoms of COVID-19 daily;

3. Continuing to use Personal Protective Equipment in accordance with the latest Centers for Disease Control and Prevention recommendations for all procedures;
4. Following waiting room spacing guidelines, Social Distancing, face masking, and other recommended procedures for patients and visitors prior to entering the facility;
5. Ensuring heightened disinfection to prevent and mitigate risk of spread;
6. Ensuring patients have been medically cleared by their primary care physician where applicable;
7. Balancing the needs of patient care with the risk of providing that care by prioritizing procedures for patients who have co-morbidities and surgical risks and procedures accompanied by lower risk regarding airborne transmission and those with minimal risk of unintended hospital admissions;
8. Performing regular rapid COVID-19 testing on providers and Workers where feasible; and
9. Performing COVID-19 testing on patients suspected to be experiencing COVID-19 and factoring the results of such testing into clinical decisions as to whether to proceed with procedures.

IT IS FURTHER

ORDERED: Any previous Executive Order or rule which would prevent Ambulatory Surgical Centers from providing the full scope of their services subject to the above requirements is hereby suspended.

IT IS FURTHER

ORDERED: That to the extent possible, hospitals, health care institutions, medical facilities, nursing homes, and other long-term care facilities should offer in-room dining.

VII. EDUCATION & CHILDREN

IT IS FURTHER

ORDERED: That nothing in this Order shall prevent any school, technical school, college, or university from requiring faculty and Workers to attend meetings or other necessary activities at a school or facility for the purpose of supporting distance learning, research, administration, maintenance, or preparation for the 2020-2021 school year.

IT IS FURTHER

ORDERED: That because of the limited resources of school districts in this state, schools and school districts offering Summer School shall not be required to comply with the ban on Gatherings, but during the effective dates of this Order, such schools and school districts ***shall*** implement additional measures to prevent the spread of COVID-19 among Summer School students. Such measures ***may*** include:

1. Screening and evaluating Workers and students who exhibit Symptoms of COVID-19;
2. Requiring Workers and students who exhibit Symptoms of COVID-19 to not report to school and to seek medical attention;
3. Enhancing sanitation of the school as appropriate;
4. Disinfecting common surfaces regularly;
5. Encouraging handwashing or sanitation by Workers and students at appropriate places within the school;
6. Prohibiting Gatherings of students on the school premises outside of instructional times;
7. Permitting students to take breaks and lunch outside, in their personal workspace, or in such other areas where proper Social Distancing is attainable;
8. Holding all meetings and conferences virtually, whenever possible;
9. Discouraging students from using other students' phones, desks, offices, or other work tools and equipment;
10. Prohibiting handshaking and other unnecessary person-to-person contact; and
11. Placing notices that encourage hand hygiene at the entrance to the school and in other areas where they are likely to be seen.

IT IS FURTHER

ORDERED: That all Child Care Learning Centers and Family Child Learning Homes under the jurisdiction of the Georgia Department of Early Care and Learning (hereinafter, "Childcare Facilities") shall maintain Worker-Child Ratios set forth by the Georgia Department of Early Care and Learning.

IT IS FURTHER

ORDERED: That all Childcare Facilities shall cease transporting children for any purpose other than transporting children between their place of residence and the Childcare Facility. To the greatest extent possible, all permissible transports shall be conducted in such a way that maintains Social Distancing.

IT IS FURTHER

ORDERED: That in addition to the requirements for businesses, establishments, corporations, non-profit corporations, or organizations that are not Critical Infrastructure set forth in Section V above and the standard hygiene, sanitation, and disinfection licensing rules promulgated by the Georgia Department of Early Care and Learning, all Childcare Facilities that operate during the effective dates of this Order ***shall*** implement additional measures to prevent the spread of COVID-19. Such measures ***shall*** include the following:

1. Screening and evaluating all children prior to them entering the classroom for Symptoms of COVID-19;
2. Prohibiting children from entering a classroom if they exhibit any Symptoms of COVID-19;
3. Prohibiting unnecessary visitors;
4. Providing meals in classrooms rather than in congregated or communal settings where possible;
5. Restricting families' access to the front door of the facility or the door of their respective child's classroom only;
6. Surfaces and objects that are frequently touched must be sanitized regularly, including, but not limited to, toys, games, and objects or surfaces not ordinarily cleaned daily;
7. Toys and games that cannot be cleaned and sanitized should not be used;
8. Toys that children have placed in their mouths or that are otherwise contaminated by body secretions or excretions should be set aside until they are cleaned by hand by a person wearing gloves;
9. Machine-washable cloth toys should be used by one individual at a time or should not be used at all and should be laundered before being used by another child;
10. Toys used by a group of children must be washed and sanitized before they may be used by children in a different group or classroom;
11. Items that need to be cleaned should be set aside in a dish pan with soapy water or in a separate container marked for soiled toys;
12. Only bedding (sheets, pillows, blankets, and sleeping bags) that can be washed may be used. Each child's bedding must be kept separate and, to the extent practicable, should be stored in individually labeled bins, cubbies, or bags. Cots and mats should be labeled for each child and any bedding that touches a child's skin should be cleaned weekly or before use by any other child; and
13. Workers should sign children in and out of the facility for families if a computer or keypad system inside the facility is used. If a tablet located outside the facility is used by families

during drop-off and pick-up, the tablet must be disinfected after each use. If a paper sign-in system is used for sign-in, writing utensils should be sanitized after each use if families are permitted to sign children in themselves.

IT IS FURTHER

ORDERED: That Overnight Summer Camps are permitted to host Campers overnight beginning May 31, 2020.

IT IS FURTHER

ORDERED: That in addition to the applicable requirements for non-Critical Infrastructure above, Summer Camps and Overnight Summer Camps ***shall*** implement additional measures to prevent the spread of COVID-19. Such measures ***shall*** include, but are not limited to, the following:

1. Placing signage at any entrance to instruct Campers that they cannot enter if they have been diagnosed with COVID-19, have exhibited Symptoms of COVID-19, or had contact with a person that has or is suspected to have COVID-19 within the past fourteen (14) days;
2. Placing signage at any entrance and throughout the facility to instruct Campers of the enhanced sanitation procedures, Social Distancing requirements, and other instructions and limitations, as applicable, set forth below;
3. Screening Campers at drop-off and preventing any Camper from entering that exhibits Symptoms of COVID-19;
4. Requiring that any persons exhibiting Symptoms of COVID-19 at any time while at the Summer Camp to be separated from the group immediately and requiring such person to leave the camp facility as soon as practicable;
5. Requiring any Worker or Camper that has stayed home sick, been prevented from entering camp due to Symptoms of COVID-19, or been sent home during camp due to Symptoms of COVID-19 shall not be permitted to attend camp again until they have either had a negative COVID-19 test or have been fever and fever medication free for seventy-two (72) hours, other Symptoms of COVID-19 have improved, and at least ten (10) days have passed since Symptoms of COVID-19 first appeared;
6. Requiring parents dropping-off and picking-up Campers to remain in their vehicles;
7. Utilizing contactless forms of Camper check-in and check-out;
8. Implementing staggered drop-off and pick-up times, with specific times for each group of Campers, if practicable;

9. Providing Hand Sanitizer to Campers as soon as practicable upon drop-off;
10. Prohibiting unnecessary visitors to camp activities and facilities;
11. Discontinuing camp tours;
12. Providing training to Workers on how to identify Symptoms of COVID-19 in Campers, the proper processes for removing a potentially ill Camper, and the infection mitigation procedures to perform in such an event;
13. Providing an isolation area for sick Workers or Campers;
14. To the extent necessary, limiting groups to twenty-five (25) persons or less, including Workers and Campers, in a space where all persons gathered cannot maintain at least six (6) feet of distance between themselves and any other person;
15. To the extent possible, keeping the same Workers and Campers in the same group for the duration of the camp;
16. Enforcing Social Distancing between groups, prohibiting Gatherings, and prohibiting congregation among Campers belonging to different groups;
17. Providing a separate designated space for each Camper to store personal belongings throughout the duration of the camp;
18. Prohibiting use of camp facilities and equipment that are not able to be regularly sanitized;
19. To the extent possible, allowing only one group to use camp equipment at a time;
20. Sanitizing camp equipment after each group use;
21. Requiring Workers to patrol camp areas to enforce the equipment sanitization policy and conduct additional cleanings during times when equipment is not being used;
22. If swimming facilities are available, allowing each group to swim only once per day and staggering swimming times to avoid crowding at the swimming facilities;
23. If camp facilities are also open to other patrons, prohibiting contact between Campers and the facility's other patrons and requiring sanitization before and after camp use of any such shared facilities;
24. Providing Hand Sanitizer stations for Campers and requiring regular use;
25. Requiring Campers to wash or sanitize their hands during each group restroom break, snack break, and meal break;
26. For day camps, if possible, requiring Campers to bring their own lunch and snacks with them to camp each day, with all such food items being in a sealed lunch bag marked with the Camper's name;

27. Requiring all dining facilities to follow the criteria for restaurant dine-in services set forth in Section IV herein to the extent practicable;
28. Requiring Workers to wear gloves when helping Campers open items from meals and snacks;
29. If camp vehicles are used for transporting Campers to and from on-site or off-site activities, requiring Workers to sanitize each vehicle before and after use;
30. Requiring Workers to clean and sanitize bathrooms and all frequently touched surfaces regularly throughout the opening hours in addition to the regular cleaning schedule. Shared restrooms must be sanitized no less than twice per day;
31. Providing masks or other Personal Protective Equipment to Workers as available and appropriate to the function and location of Workers within the camp facility; and
32. Providing masks or other Personal Protective Equipment to Campers as available and appropriate to the activity and location of Campers within the camp facility; and
33. Overnight Summer Camps shall implement the following additional measures:
    a. Campers and Workers shall be tested for COVID-19 prior to beginning an Overnight Summer Camp. Overnight Campers and Workers shall not be permitted to begin any Summer Camp unless they have received a negative test result for COVID-19 within seven (7) days prior to beginning an Overnight Summer Camp. A Camper or Worker who receives a positive test result for COVID-19 shall not be allowed access to any Overnight Summer Camp facilities or Overnight Summer Camp activities until either:
        i. The Camper or Worker has had no fever for at least seventy-two (72) hours, without taking fever-reducing medication, and
        ii. The Camper's or Worker's Symptoms of COVID-19 have shown progressive improvement, and
        iii. At least ten (10) days have elapsed from the date Symptoms of COVID-19 began,

        or

        i. For a Camper or Worker who has received a laboratory-confirmed positive test result, but who has experienced no Symptoms of COVID-19, until at least ten (10) days have

elapsed since the date of the first positive diagnostic test.

b. Screening Workers and Campers each morning and evening. Persons exhibiting Symptoms of COVID-19 shall be separated from the group immediately and must leave the camp facility as soon as practicable;
c. Requiring Workers to clean and sanitize overnight bunk rooms at least once per day;
d. Sanitizing bunks and bunk mattresses at least once per week and before and after use by a new Worker or Camper;
e. Limiting camp occupancy to the extent necessary to maintain overnight bunk room occupancy at twenty-five (25) persons, including Workers and Campers, or less per room;
f. To the extent possible, arranging beds and bunk beds in overnight bunk rooms so that beds are six (6) feet apart and in a foot-to-foot style; and
g. Requiring a Registered Nurse or Licensed Practical Nurse to be on site during all times that Campers are present at the camp facility to the extent practicable.

IT IS FURTHER

ORDERED: That all Campers and Workers who stay overnight at an Overnight Summer Camp must remain on the Summer Camp premises at all times, except in case of emergency or for purposes of participating in an off-site activity that is part of the Overnight Summer Camp's program. Any Camper or Worker who leaves the premises of an Overnight Summer Camp for any reason shall be required to receive an additional negative test result for COVID-19 prior to re-entry. This provision shall not apply to Workers at Summer Camps who do not stay overnight, provided that such Workers wear a face covering and practice strict Social Distancing while on the premises of the Overnight Summer Camp.

IT IS FURTHER

ORDERED: That a Camper or Worker at a Summer Camp or an Overnight Summer Camp with known exposure to COVID-19 shall not be allowed access to any Summer Camp or Overnight Summer Camp, including any facilities or activities, until at least fourteen (14) days have elapsed since the last known exposure.

IT IS FURTHER

ORDERED: That Code Section 15-11-2(10) relating to the definition of "child" is suspended for the limited purpose of ensuring that persons in the care of the Georgia Division of Family & Children Services who age out of the definition of "child" during the Public Health State of Emergency shall be eligible to remain in their placement and continue to receive services for a duration of ninety (90) days following the termination of the Public Health State of Emergency or any extension thereof. This suspension shall apply to Code Section 15-11-2(10), effective until July 1, 2020, and upon expiration to Code Section 15-11-2(10), effective July 1, 2020. Any Georgia Division of Family & Children Services policies shall also align with this provision.

IT IS FURTHER

ORDERED: That no provision of this Order shall limit, infringe, suspend, or supplant any custodial arrangements created pursuant to the laws or constitution of this State or the laws or constitution of the United States, nor shall any person use any provision of this Order as a defense to an action in violation of a custodial arrangement by any court created pursuant to the laws or constitution of this State or the laws or constitution of the United States.

VIII. GOVERNMENTS

IT IS FURTHER

ORDERED: That for the purposes of Code Section 48-5-311(e)(6A), "in-person" appearances before county boards of equalization may occur via remote communications, including, but not limited to, video teleconference. This provision shall be implemented consistent with Ga. Comp. R. & Regs. r. 560-11-12-.02, which requires hearings before county boards of equalization to "only be as formal as is necessary to preserve order and be compatible with the principles of justice." Further, this provision does not abrogate the requirement that county boards of equalization comply with the Georgia Open Meetings Act.

IT IS FURTHER

ORDERED: That the requirements of Code Section 36-70-27 and 50-8-8 are hereby suspended to the extent that they would prevent local governments from being eligible to receive state funding for expenditures made during the current Public Health State of Emergency related to the prevention, treatment, or mitigation of COVID-19.

IT IS FURTHER

ORDERED: That county and municipal governments are authorized and empowered to make, amend, and rescind such orders, rules, and regulations as may be necessary for emergency management purposes and to supplement the carrying out of this Order, but such orders, rules, and regulations shall not be inconsistent with this Order or any other orders, rules, or regulations promulgated by the Governor or by any state agency exercising a power derived from the Public Health State of Emergency declaration. For the purpose of this provision, orders, rules, and regulations that are promulgated by county and municipal governments that are more or less restrictive than the terms of this Order shall be considered inconsistent with this Order.

IT IS FURTHER

ORDERED: That the operation of Critical Infrastructure shall not be impeded by county, municipal, or local ordinance.

IX. ENFORCEMENT

IT IS FURTHER

ORDERED: That the state agencies with primary regulatory authority over the entities listed in this Order and the Commissioner of the Department of Public Safety shall provide resources as requested to assist in the enforcement of this Order.

IT IS FURTHER

ORDERED: That pursuant to Code Section 38-3-7, any person who violates this Order shall be guilty of a misdemeanor. Officials enforcing this Order should take reasonable steps to provide notice prior to issuing a citation or making an arrest. No provision of this Order shall limit the ability of law enforcement officers to enforce the laws of this State. Particularly, the provisions of Code Section 38-3-4 remain in effect, and all law enforcement is authorized to enforce the Orders issued pursuant to Title 38, Chapter 3.

IT IS FURTHER

ORDERED: That any law enforcement officer, after providing reasonable notice and issuing at least two citations for violations of Code Section 38-3-7, is authorized to mandate the closure of any business,

establishment, corporation, non-profit corporation, or organization not in compliance with this Order for a period not to extend beyond the term of this Order.

IT IS FURTHER

ORDERED: That pursuant to Executive Order 04.02.20.01 and Code Section 38-3-51, enforcement of any county or municipal ordinance or order that is more or less restrictive than this Order is hereby suspended.

X. MISCELLANEOUS

IT IS FURTHER

ORDERED: That if one or more of the provisions contained in this Order shall conflict with the provisions of any previous Executive Order or Agency Administrative Order, the provisions of this Order shall control. Further, in the event of any conflict, the provisions of any Quarantine or Isolation Order issued to a specific person by the Department of Public Health shall control.

IT IS FURTHER

ORDERED: That nothing in this Order shall be construed to suspend or limit the sale, dispensing, or transportation of firearms or ammunition, or any component thereof.

IT IS FURTHER

ORDERED: That if one or more of the provisions contained in this Order shall be held to be invalid, in violation of the Georgia Constitution, in violation of Georgia law, or unenforceable in any respect, such invalidity, violation, or unenforceability shall not affect any other provisions of this Order, but, in such case, this Order shall be construed as if such invalid, illegal, or unenforceable provision had never been contained within the Order.

IT IS FURTHER

ORDERED: That no provision of this Order shall limit, infringe, suspend, or supplant any judicial order, judgment, or decree issued pursuant to the laws or constitution of this State or the laws or constitution of the United States, nor shall any person use any provision this Order as a defense to an action in violation of a judicial order, judgment, or decree by any court created pursuant to the laws or constitution of this State or the laws or constitution of the United States.

IT IS FURTHER

ORDERED: This Order does not attempt, nor shall it be construed, to imply that the Governor, in any instance, has the unilateral authority to overturn any judicial order, judgment, or decree.

IT IS FURTHER

ORDERED: The Office of the Governor may continue to issue guidance on the scope of this Order as needed through communication media, including social media, without need for further Executive Orders.

XI. EFFECTIVE DATE & SIGNATURE

IT IS FURTHER

ORDERED: That this Order shall be effective upon signature.

This 28th day of May 2020, at 3:57 A.M./P.M.

B. P.

GOVERNOR

May 28, 2020 Governor Kemp Executive Order
Section IV: Restaurants & Dining Services

May 28, 2020 Executive Order

The provisions contained in this Order shall be effective from June 1, 2020 at 12:00 A.M. until June 15, 2020 at 11:59 P.M.

No more than ten (10) patrons should be allowed in the facility per 300 square feet of public space. In calculating the total number of public space square feet, such calculation shall include waiting and bar areas as well as patios or any outdoor dining space, if any, but shall not include hallways, restrooms, and spaces closed to patrons.

Is the kitchen included in the square footage?
The square footage does not include the kitchen, hallways, restrooms, and areas closed to patrons. The square footage calculation should only include areas of the restaurant that would normally be open to guests.

All Restaurants and Dining Rooms as well as all banquet facilities, private event facilities, and private reception venues where food is served *(NEW as of May 28, 20202 order)* that operate during the effective dates of this Order shall implement measures which mitigate the exposure and spread of COVID-19 among its patrons and workforce. Such measures shall include the following:

1. Screen and evaluate Workers who exhibit Symptoms of COVID-19;

Do I have to take employees' temperature?
It is your choice to take employees' temperatures or not. If you do decide to implement temperature-taking, be sure to do so in a fair, non-invasive manor. To avoid HIPPA violations, it is generally suggested that employers use employee numbers instead of recording names to protect their privacy. Documentation is important and the screening procedures should be consistent for all employees. Please be sure to consult with your trusted advisor for guidance on how best to meet these requirements for your business.

Where can I buy thermometers?
As of April 29, iHealth Labs has no-touch thermometers in stock for $43.99 each: https://ihealthlabs.com/thermometer-pt3/

2. Require Workers who exhibit Symptoms of COVID-19 to not report to work or to seek medical attention. Per existing U.S. Food and Drug Administration Food Code requirements, Workers who are sick should remain home. If a Worker becomes ill or presents Symptoms of COVID-19 at work, the operator should identify the Worker's condition during a pre- work screening and send the Worker home. Restaurants shall create, maintain, and follow established policies regarding when Workers who have become ill are permitted to return to work. A Worker with known or suspected COVID-19 must follow Centers for Disease Control and Prevention guidelines to self-isolate for at least ten (10) days after onset of Symptoms of COVID-19 and end isolation only after Symptoms of COVID-19 have improved and the Worker has been fever-free and/or free of Symptoms of COVID-19 for three (3) consecutive days without medication before returning to work;

What guidance should I be following for the reopening process?
The Georgia Restaurant Association has worked with the National Restaurant Association, representatives of the Food and Drug Administration, academia, the Conference for Food Protection, Ecolab, the Georgia Department of Public Health and industry representatives to develop a set of opening and operating guidelines specific to Georgia to help restaurants return to full operation safely when the time comes.

This guidance is designed to provide restaurants with a basic summary of recommended practices that can be used to help mitigate exposure to the COVID-19 virus, including: food safety, cleaning and sanitizing, employee health and social distancing.

We trust each individual restaurant will use the resources provided to make a responsible choice that is best for their business and their community.

The FDA has also published guidance for employers.

3. Implement teleworking for all possible Workers;

4. Implement staggered shifts for all possible Workers;

5. Hold all meetings and conferences virtually, whenever possible;

6. Train all Workers on the importance and expectation of increased frequency of handwashing, the use of Hand Sanitizers with at least 60% alcohol, and provide clear instruction to avoid touching hands to face;

7. Require all Workers to wear face coverings at all times. Workers may also wear face shields in addition to their face coverings. Such face coverings and face shields shall be cleaned or replaced daily;

What counts as a face covering?
Face coverings must cover the nose and mouth when being worn. CDC: Use of Cloth Face Coverings to Help Slow the Spread of COVID-19

Are face coverings required even if we don't open our dining room?
Yes. The Executive Order specifies wearing face coverings "at all times". Face coverings protect everyone — staff, delivery drivers, customers picking up orders, etc.

Are plastic face shields considered an appropriate face covering, or do we need a mask as well?
No, face shields are not appropriate face coverings on their own. If you wear a plastic shield, you must also wear a face covering that covers your nose and mouth.

What if we cannot obtain a sufficient supply of face covers by the time we open?
While companies like Sysco have face masks in stock, the Executive Order's usage of the term face covering means cloth coverings like bandanas would be sufficient. It is just important that the face covering is cleaned or replaced every day. CDC: Use of Cloth Face Coverings to Help Slow the Spread of COVID-19

Are guests required to wear face coverings to dine in?
No, they are not, however the CDC now recommends that everyone wear a face covering when out in public.

8. Discourage Workers from using other Workers' phones, desks, offices, or other work tools and equipment;

9. Where possible, stagger workstations to avoid Workers standing adjacent to one another or next to each other. Where six (6) feet of separation is not possible, consider spacing options that include other mitigation efforts with increased frequency of cleaning and sanitizing surfaces;

Are there any guidelines on social distancing or number of people in the kitchen?
There are no specific guidelines for the kitchen. Enforce six-foot social distancing as much as possible. Be sure to have your menu reflect the fact that you will likely have less people in the kitchen than before.

10. Establish a limit for the maximum number of Workers permitted in Worker breakrooms to reduce contact;

11. Prohibit handshaking and other unnecessary person-to- person contact in the workplace;

12. Enforce Social Distancing of non-cohabitating persons while present on such entity's leased or owned property;

Can we seat two different families together? What about two friends?
You can seat two families or two friends together if they live together. Just remember, you cannot sit more than ten people at the same table. (See Guideline #28.)

How do we enforce this?
It is recommended that you let guests know about this guideline and ask the question. For example, "As you probably are aware, the Governor's Order prohibits us from seating people who don't live in the same household together so I just need to verify that you live in the same household before I can seat you at a table together – so, do you live in the same household?"

13. Increase physical space between Workers and patrons;

14. Limit contact between Workers and patrons;

How are we able to serve our customers if we are practicing social distancing?
The server can bring the food or beverages to the table and step away; no lingering.

15. Discard all food items that are out of date;

16. Discontinue use of salad bars and buffets, unless the salad bar or buffet is being used for cafeteria style service where a Worker is responsible for serving the patron, handling the utensils, and ensuring proper distancing in lines;

17. If providing a "grab and go" service, stock coolers to no more than minimum levels;

18. Ensure the Food Safety Manager certification of the person in charge is up-to-date and provide food handler training to refresh Workers;

Where can I find these classes?
Manager training can be found HERE. Food Handler training can be found HERE. ServSafe® also created three new, free, on-demand training videos specifically for COVID-19 including ServSafe Takeout, ServSafe Delivery, and ServSafe Reopening Guidelines.

19. Thoroughly detail, clean, and sanitize the entire facility prior to resuming dine-in services and continue to do so regularly, focusing such cleaning and sanitation on high contact areas that would be touched by Workers and/or patrons;

20. Between diners, clean and sanitize table condiments, digital ordering devices, check presenters, self-service areas, tabletops, and commonly touched areas, and discard single use items;

21. Use rolled silverware and eliminate table presets;

22. Remove items from self-service drink, condiment, utensil, and tableware stations and have Workers provide such items to patrons directly wherever practicable;

> **Do we have to shut down drink machines?**
> *Customers can use self-serve drink machines as long as social distancing is practiced and you provide the cups, lids and straws to each customer.*

23. The use of disposable paper menus is strongly encouraged, which should be discarded after each patron use. Otherwise, businesses subject to this Section shall clean and sanitize reusable menus between each use by a patron. Non-touch menus are also acceptable for use;

24. Clean and sanitize restrooms regularly, check restrooms based on the frequency of use, and always ensure adequate supply of soap and paper towels;

> **Are paper towels required in restrooms or are hand dryers sufficient?**
> *Both drying methods are fine. It is important to maintain an ample supply of hand soap. If you have a hand dryer that must be touched to turn on, make sure to sanitize it frequently.*

25. Implement procedures to increase cleaning and sanitizing frequency of surfaces in the back-of-house. Avoid all food contact surfaces when using disinfectants;

26. Verify that ware-washing machines are operating at the required wash and rinse temperatures and with the appropriate detergents and sanitizers;

27. Update floor plans for common dining areas, redesigning seating arrangements to ensure at least six (6) feet of separation from seating to seating. Utilize physical barriers on booth seating when available to ensure Social Distancing;

28. Limit party size at tables to no more than ten (10);

29. Where practical, consider a reservations-only business model or call-ahead seating;

30. Remind third-party delivery drivers and any suppliers of your internal distancing requirements;

31. Post signage on entrances that no one with Symptoms of COVID-19 is permitted in the facility;

What should the sign say?
The sign must say "No one with symptoms of COVID-19 is permitted in the facility"; you may include other guidelines for guests such as requiring face coverings, if you choose to implement those guidelines.

Do you have a sign I can print?
Click HERE to download a sign you can print and post on your entrance door.

What are the symptoms of COVID-19?
According to the CDC, people with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea

Do we have to take customers' temperatures?
No, you do not have to take the temperatures of your customers, but if they are exhibiting symptoms you should not allow them on site.

32. Where practicable, physical barriers such as partitions or Plexiglas at registers should be used;

33. Use technological solutions where possible to reduce person- to-person interaction: mobile ordering, mobile access to menus to plan, text on arrival for seating, and contactless payment options;

34. Provide Hand Sanitizer for use by patrons, including contactless hand sanitizing stations when available;

What counts as hand sanitizer?
"Hand sanitizer" means "any hand antiseptic, hand rub, soap, or agent applied to the hands for the purpose of removing common pathogens". (Definition from April 27, 2020 Executive Order)

35. Do not allow patrons to congregate in waiting areas or bar areas. Design a process to ensure patron separation while waiting to be seated that can include floor markings, outdoor distancing, or waiting in cars;

How can we do this?
It is strongly encouraged that you utilize directional tape and/or signage.

36. If possible, use an exit from the facility separate from the entrance;

How can we do this?
It is strongly encouraged that you utilize directional tape and/or signage.

37. Mark ingress/egress to and from restrooms to establish paths that mitigate proximity for patrons and Workers;

How can we do this?
It is strongly encouraged that you utilize directional tape and/or signage.

38. Where practicable, take-out and curbside pick-up services should be prioritized over dine-in services; and

39. All restaurant or dining room playgrounds shall be closed.

None of the provisions of Section IV of this Order, titled "Restaurants & Dining Services," shall apply to the operation of dine- in services in hospitals, health care facilities, nursing homes, or other long-term care facilities, but such facilities should implement measures to prevent the spread of COVID-19 if possible.

The routine inspection timelines under Georgia Administrative Rule 511-6-1-.10(2) may be extended by the Georgia Department of Public Health by one hundred and twenty (120) days for any permit holder of a food service establishment maintaining an "A" food safety grade for any such food service establishment which was scheduled to have a routine inspection at any time between March 14, 2020 and September 10, 2020.

Message

From: Carter-Jenkins, Shakeba [Carter-Jenkins.Shakeba@epa.gov]
Sent: 7/15/2020 3:01:33 PM
To: Vizian, Donna [Vizian.Donna@epa.gov]
Subject: RE: Final Phase 3 Plan
Attachments: Phase 3 July 14 final draft.docx

Hi, Here you go.

Shakeba Carter-Jenkins
Communications Director &
Senior Special Assistant
Office of Mission Support, U.S. Environmental Protection Agency
carter-jenkins.shakeba@epa.gov | 202-564-6385 | Ex. 6 Personal Privacy (PP) *(mobile) | WJC North 3330*
Mailing Address: 1200 Pennsylvania Avenue, NW, Washington, DC 20460

"I've learned you can tell a lot about a person by the way (s)he handles these three things: a rainy day, lost luggage, and tangled Christmas tree lights." Maya Angelou

From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Wednesday, July 15, 2020 11:00 AM
To: Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: FW: Final Phase 3 Plan

Do you have the pretty document that I can email?

From: Patterson, Nicole <Patterson.Nicole@epa.gov>
Sent: Wednesday, July 15, 2020 9:51 AM
To: Newton, Cheryl <Newton.Cheryl@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>
Cc: Szaro, Deb <Szaro.Deb@epa.gov>; Vizian, Donna <Vizian.Donna@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>; Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: Re: Final Phase 3 Plan

Donna - I'm good with the plan.

Nicole Patterson, OHR
(202) 564-4839; patterson.nicole@epa.gov

On Jul 15, 2020, at 8:45 AM, Newton, Cheryl <Newton.Cheryl@epa.gov> wrote:

Thanks Deb – This is helpful, and I appreciate the offer of a possible call. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)

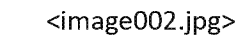
Ex. 5 Deliberative Process (DP)

If I am the only one struggling with this, I would welcome a call and tutorial☺ Thanks!

From: Szaro, Deb <Szaro.Deb@epa.gov>
Sent: Wednesday, July 15, 2020 6:47 AM
To: Vizian, Donna <Vizian.Donna@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>
Cc: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: RE: Final Phase 3 Plan

Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP)



From: Vizian, Donna <Vizian.Donna@epa.gov>
Sent: Tuesday, July 14, 2020 6:34 PM
To: Szaro, Deb <Szaro.Deb@epa.gov>; Newton, Cheryl <Newton.Cheryl@epa.gov>; Hitchens, Lynnann <hitchens.lynnann@epa.gov>; Kamen, Mara <kamen.mara@epa.gov>; Hunt, Loretta <Hunt.Loretta@epa.gov>; Patterson, Nicole <Patterson.Nicole@epa.gov>; Hart, Debbi <Hart.Debbi@epa.gov>; Shaw, Betsy <Shaw.Betsy@epa.gov>; Packard, Elise <Packard.Elise@epa.gov>
Cc: Braxton, Marilyn <Braxton.Marilyn@epa.gov>; Carter-Jenkins, Shakeba <Carter-Jenkins.Shakeba@epa.gov>
Subject: Final Phase 3 Plan

Hi Everyone,

Thanks again for all your help with this. Attached is the version that Doug approved. Ex. 5 Deliberative Process (DP)

Ex. 5 Deliberative Process (DP) Nicole, can you please give it a last read.

Ex. 5 Deliberative Process (DP)

EPA Facility Status Dashboard

About | Home | Criteria I | Criteria II | Criteria III

Last updated: 06/03/2020

EPA Facilities

- COVID-19 cases are not trending down
- COVID-19 cases are trending down over the previous 7 days
- COVID-19 cases are trending down over the previous 14 days

OR incidence rate is below 10 per 100,000 people over the previous 14 days

Boston, MA 02121-0000

Region 2 Headquarters
290 Broadway
New York City, NY 10007-1866

Region 3 Headquarters
1650 Arch Street
Philadelphia, PA 19103-2029

Region 4 Headquarters
61 Forsyth Street SW
Atlanta, GA 30303-8960

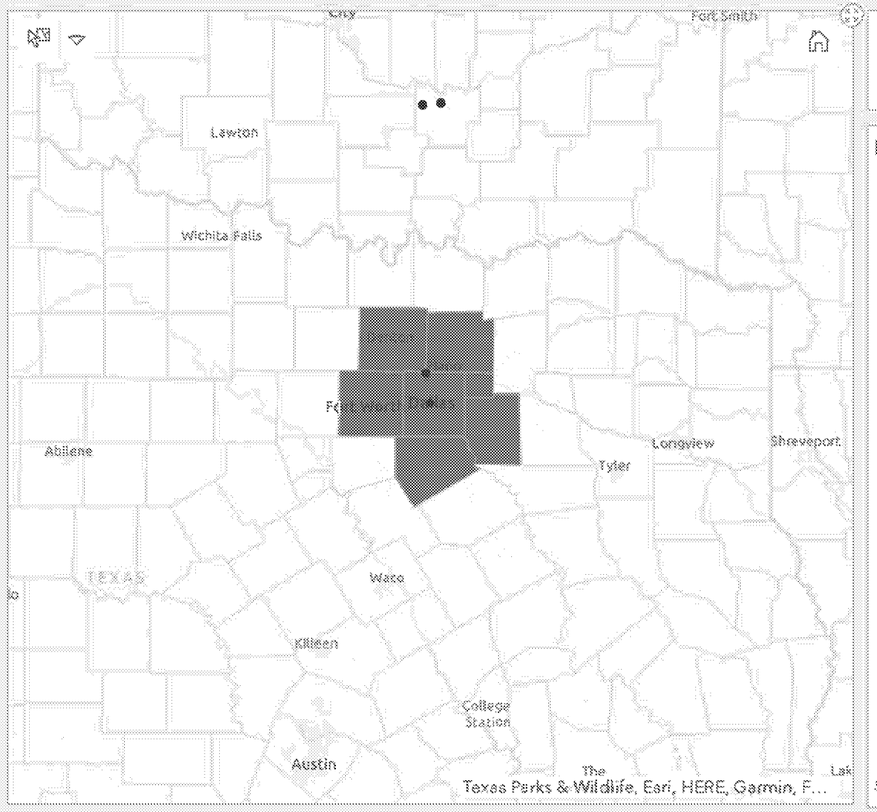
Region 5 Headquarters
77 West Jackson Boulevard
Chicago, IL 60604-3511

Region 6 Headquarters
1201 Elm Street
Dallas, TX 75270-0000

Region 7 Headquarters
11201 Renner Blvd
Lenexa, KS 66219

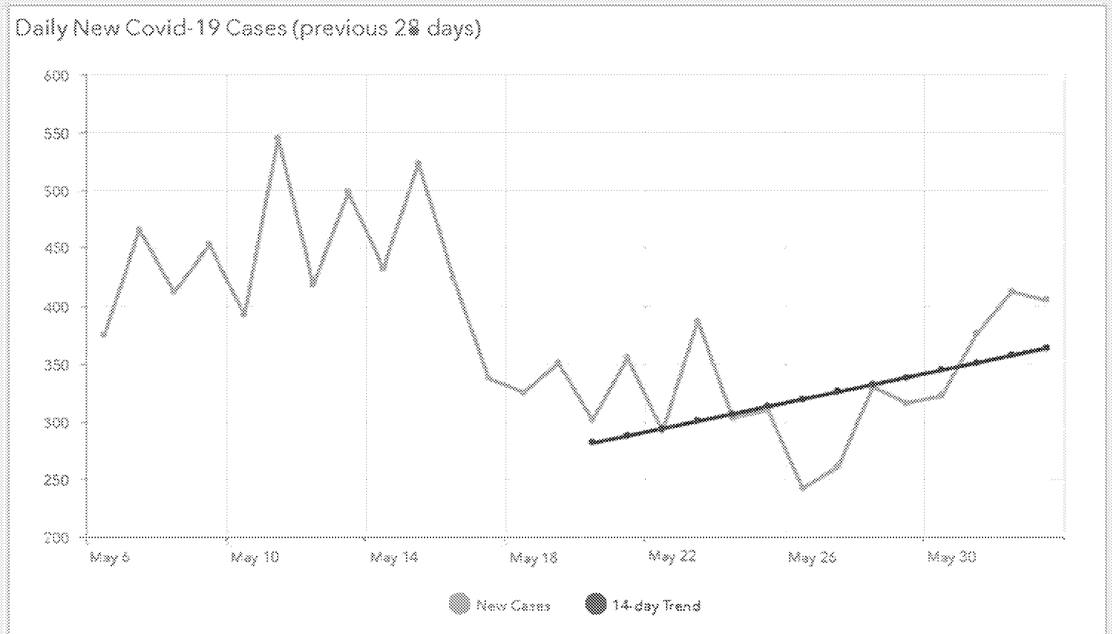
Region 8 Headquarters
1695 Wynkoop Street
Denver, CO 80202-0000

Region 9 Headquarters
75 Hawthorne Street
San Francisco, CA 94105-3920



Criteria II

Documented COVID-19 cases and prevalence of positive tests must trend downward for 14 days (while not decreasing the overall number of tests)



See About Tab for how trend was determined

Population
6,765,305

Confirmed COVID-19 Cases (all cases)
20,581

COVID-19 Incidence Rate (previous 14 days)
67.2
cases per 100,000 people

14 Day Trend
New COVID-19 cases are trending up over the previous 14 days
Goal: Downward trend for 14 days

14 Day Trend
This trend is statistically significant
p-value = 0.0369

EPA Facility Status Dashboard

About | Home | Criteria I | Criteria II | Criteria III

Last updated: 06/03/2020

EPA Facilities

- Facility is not meeting all criteria
- Facility is meeting all criteria over the previous 7 days
- Facility is meeting all criteria over the previous 14 days

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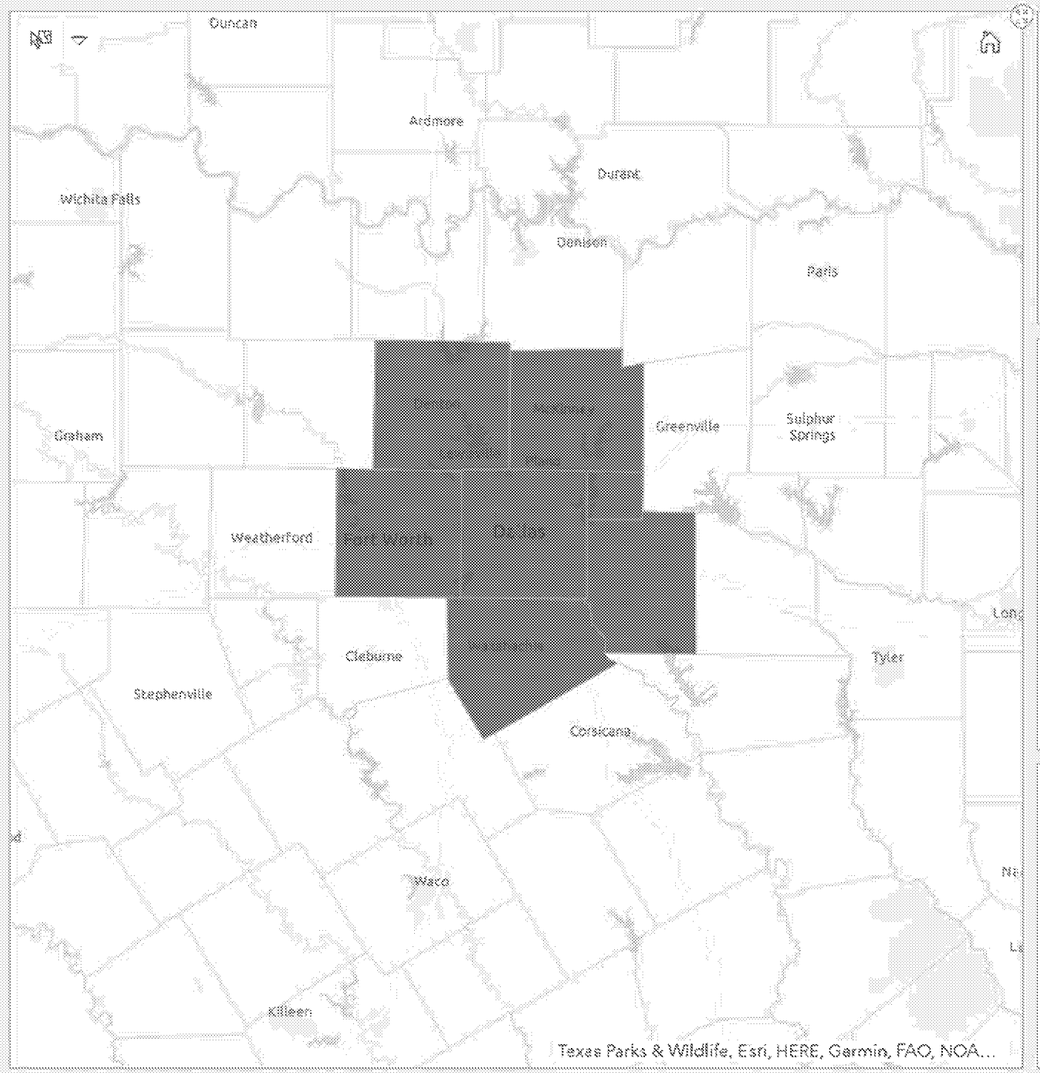
San Francisco, CA 94105-3920

Region 10 Headquarters
1200 Sixth Avenue
Seattle, WA 98101-3188



Criteria I

Downward trajectory of influenza and COVID-like illness (ILI / CLI) symptoms within 14-day period

Goal I-a: Number of reported weekly new ILI symptoms averaged over the states that intersect the commuting area trends down over a 4-week period

AND

Goal I-b: Number of reported weekly new CLI symptoms averaged over the states that intersect the commuting area trends down over a 4-week period

Criteria II

Documented COVID-19 cases and prevalence of positive tests must trend downward for 14 days (while not decreasing the overall number of tests

Goal II-a: Number of reported daily new cases in the commuting area trends down over a 14-day period

AND

Goal II-b: Number of reported positive tests in the commuting area trends down over a 14-day period

OR

Goal II-c: Incidence over the previous 14 days is less than 10 cases per 100,000 people

Criteria III

Local hospitals must have the capacity to treat all patients without crisis care and jurisdictions must have a robust healthcare worker testing program and plan in place

Goal III-a: ICU bed capacity for all hospitals in the commuting area is greater than 20%

AND

Goal III-b: Percent of positive tests averaged over the states that intersect the commuting area is below 20%

Goal I-a

Statewide ILI Symptoms are trending down over the previous 4 weeks

Goal I-b

tbd

Goal II-a

New COVID-19 cases are not trending down over the previous 14 days

Goal II-b

tbd

Goal II-c

Incidence over last 14 days

67.2

cases per 100,000 people

Goal III-a

ICU Capacity Remaining

44.0%

Goal III-b

Percent of COVID-19 tests that are positive

6.9%

EPA Facility Status Dashboard

About | Home | Criteria I | Criteria II | Criteria III

Last updated: 06/03/2020

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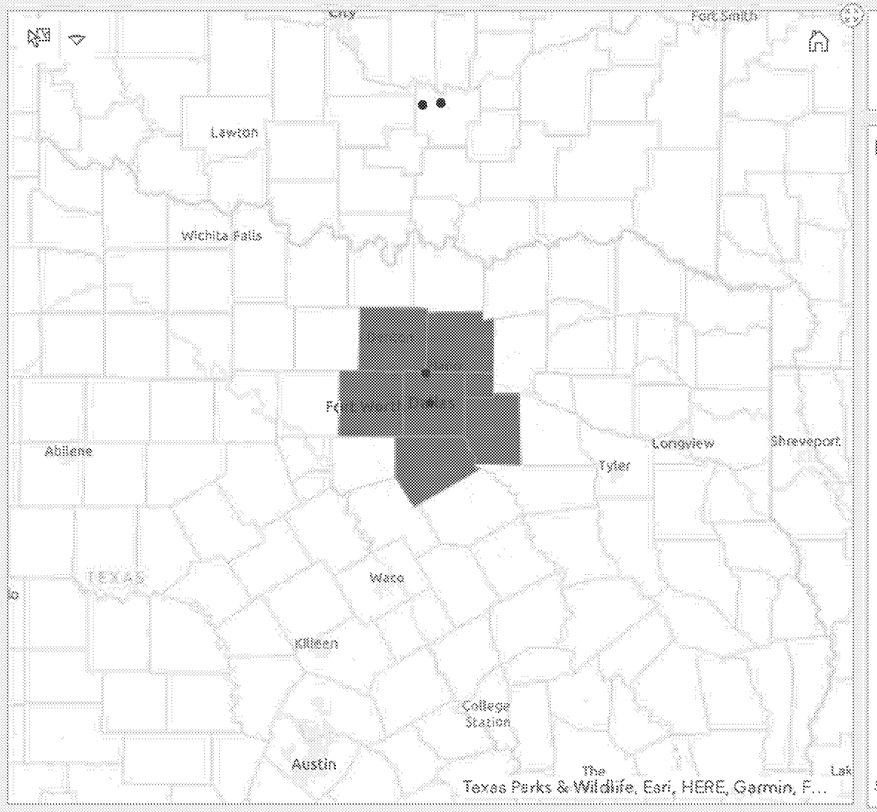
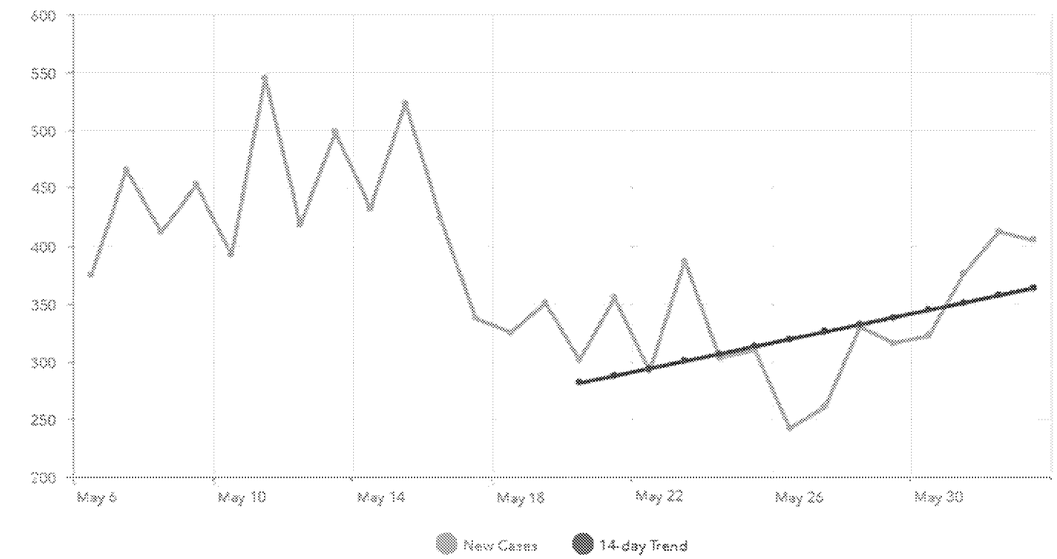


Criteria II

Documented COVID-19 cases and prevalence of positive tests must trend downward for 14 days (while not decreasing the overall number of tests)

Daily New Covid-19 Cases (previous 28 days)



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14 Day Trend

This trend is statistically significant

p-value = 0.0369